

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Stone
 Township Washington
 City Galena Mo.

Registration District No. 843File No. 15919Primary Registration District No. 6104Registered No. 2

(NO. _____)

St. _____

Ward _____

[If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number]

FULL NAME Raymond Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE ☒ MARRIED ☒
 WIDOWED ☒ OR DIVORCED ☒
 (Write the word)

DATE OF BIRTH

April 1st, 1912
 (Month) (Day) (Year)

AGE

20 yrs. 70 mos. 20 ds.

IF LESS than
 1 day ☒ hrs.
 or ☒ min.?

OCCUPATION

Trade, profession, or
 particular kind of work ☒

(b) General nature of industry,
 business, or establishment in
 which employed (or employer) ☒

BIRTHPLACE

(City or town;
 State or foreign country)

Galena Mo.

NAME OF FATHER

George H. Barnes

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Lawrence G. Mo.

MAIDEN NAME OF MOTHER

Katie Norris

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Topeka Kas.

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature) Geo. H. Barnes

(ADDRESS)

Galena Mo.

April 21, 1912

J. McLeod

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

April 21st, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Apr. 19, 1912, to Apr. 20th, 1912,

that I last saw him alive on Apr. 20, 1912,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis1068. 89

(Duration) ☒ yrs. ☒ mos. 3 or 4 ds.

Contributory

(SECONDARY)

(Duration) ☒ yrs. ☒ mos. 4 ds.

(Signed)

L. Henson

M. D.

191

(Address)

Galena Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
 if not at place of death?

Former or
 usual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

April 22, 1912

UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____

Ward _____

(If death occurred in hospital or institution, give its NAME and street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If more than one, give the word)
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DATE OF BIRTH

_____, 191____, 1____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) _____

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191____,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____, 1____ (Day) _____ (Month) _____

I HEREBY CERTIFY, that I attended deceased _____

_____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

County Stone
Township Washington
Village Mr.
City (NO.)

Registration District No. 843

Primary Registration District No. 6106

File No. 15919
Registered No. 2

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]

FULL NAME Raymond Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE S.
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Apr. 1st 912
(Month) (Day) (Year)

AGE 30
yrs. mos. ds. If LESS than
1 day, hrs. or min.

OCCUPATION
(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Es. H Barnes

(ADDRESS) Galena Mo.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 19th 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Apr. 19, 1912, to Apr. 20, 1912,
that I last saw him alive on Apr. 20, 1912,
and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis

Contributory
(SECONDARY)

(Duration) 3 yrs. 4 mos. 8 ds.
(Signed) L. H. Hunsy M. D.
(Address) Galena Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)

At place of death 3 yrs. 4 mos. 8 ds. In the State 3 yrs. 4 mos. 8 ds.

Where was disease contracted
if not at place of death?

Former or
usual residence.

PLACE OF BURIAL OR REMOVAL

Galena Mo.

DATE OF BURIAL

Apr. 22 1912

UNDERTAKER

Don't know

ADDRESS

X

Filed April 23 1912 X W. M. Cord X
REGISTRAR

Original file, date APR 23 1912 All information called for must be written on this Supplementary Certificate.

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Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)