

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

PLACE OF DEATH

County Livingstone

Township _____

Village _____

City Chillicothe (NO. _____)

Registration District No. 508

File No. 20612

Primary Registration District No. 3026

Registered No. 70

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

FULL NAME Wm. N. Lowell

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)
DATE OF BIRTH <u>Feb. 10, 1883</u> (Month) (Day) (Year)		
AGE <u>79</u> yrs. <u>4</u> mos. <u>2</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>1 - [unclear]</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Tenn.</u>		
PARENTS	NAME OF FATHER <u>Elias Lowell</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant E. N. Lowell

(ADDRESS) Road No.

Filed 6/13 1912 R. Barney

REGISTRAR J. Mohr

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 12, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 6/12, 1912, to 6/12, 1912,

that I last saw him alive on May 2, 1912

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

The CAUSE OF DEATH* was as follows:

Railway accident
2076
Run over by freight car
while crossing Railway tracks

Contributory "Deaf"

(Duration) yrs. mos. ds.

(Signed) R. Barney M. D.

6/13 1912 (Address) Chillicothe

*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 Person Creek Cemetery

DATE OF BURIAL June 14, 1912

UNDERTAKER J. Mohr

ADDRESS Chillicothe

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward _____

(If death in hospital give its No. of street and _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____

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

OCCUPATION _____
(a) Trade, profession, or 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 _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended dece _____, 191____, to _____, that I last saw h _____ alive on _____ and that death occurred, on the date stated above, at _____
 The CAUSE OF DEATH* was as follows:

Contributory _____ yrs. _____ mos.

(Duration) _____ yrs. _____ mos.

(Signed) _____ 191____ (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, TRANSIENT RESIDENTS)

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

Give us street and number

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Livingston
Township _____
or
Village _____
or
City Chillicothe (NO. _____ St. _____ Ward _____)

Registration District No. 508 File No. 20612
Primary Registration District No. 3026 Registered No. 70

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

FULL NAME Wm. N. Dowell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

DATE OF DEATH June 12, 1912
(Month) (Day) (Year)

DATE OF BIRTH Feb. 10, 1833
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 6/12, 1912, to 6/12, 1912, that I last saw him alive on May 1, 1912.

AGE 79 yrs. 4 mos. 2 ds. If LESS than 1 day, _____ hrs. or _____ min.

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

OCCUPATION (a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

The CAUSE OF DEATH* was as follows:

BIRTHPLACE (City or town, State or foreign country) Peru, Mo.

Railway accident
Ran over by freight car
while crossing R.R. track.
(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER Elias Dowell

Contributory None
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known

(Signed) R. Barney M. D.
6/12, 1912 (Address) Chillicothe

MAIDEN NAME OF MOTHER Elizabeth (unknown)

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

Informant) E. W. Dowell
(ADDRESS) Hale Mo.

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

Filed 8/9/12 1912 R. Barney REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Parson Creek Cem DATE OF BURIAL June 14, 1912

UNDERTAKER J. Mohr + Son ADDRESS Chillicothe

Original file, date JUN, 1912

All information called for must be written on this Supplementary Certificate.

FULL NAME

mpatron.—Precis
trant, so that the
suits can be know
every person, irre
a single word or
e, g., *Farmer* or *P
Locomotive enginee
But in many c
is, it is necessary
o (b) the nature o
an additional lin
it should be used o
inner, (b) *Cotton m
eman, (b) Automob
may form part of 1
"Laborer," "Forem
ut more precise spe
Laborer—Coal mi
aged in the duties
keepers who receive
ousewife, Housework
y employed, as *At h
to report specificall
n domestic service f
id, etc. If the occu
on account of the
tion at beginning
that fact may be
(s.) For persons wh
the *None*.
cause of death.—
ARTH (the primary
causation), using
the same disease.
only definite synon
fer (never report
monia; *Bronchop
igitis"); Diphtheri
fer (never report
umonia; *Bronchop
is indefinite); *Tub
m, etc., *Carcinoma
origin; "Cancer" is*******

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, peritoneum*, 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.)