

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Wright
Township Boron Sp
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 909 File No. 22113
Primary Registration District No. 6224 Registered No. 7

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

FULL NAME Benjamin Harrison Todd

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE <u>single</u> MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Aug 13</u> 1888 (Month) (Day) (Year)		
AGE <u>23</u> yrs. <u>9</u> mos. <u>13</u> ds. IF LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>I. O. P.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u> 10th		
PARENTS	NAME OF FATHER <u>John P. Todd</u> 11th	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Martha C. Newton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 26 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 4th, 1912, to May 26, 1912, that I last saw him live on May 14th, 1912, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Obseps of the stomach
Gabriel
Taking Opium pills at first
so said by Physicians who
treated him (Duration) _____ yrs. 8 mos. _____ ds.

Contributory Opium Ball playing
(SECONDARY) responsibility (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. H. Hanson M. D.
May 29 1912 (Address) Hartsville

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Todd
(ADDRESS) Odin

PLACE OF BURIAL OR REMOVAL <u>Wd Giron</u>	DATE OF BURIAL <u>May 25</u> 1912
UNDERTAKER <u>Pat Whelchel</u>	ADDRESS <u>Hartsville</u>

Filed June 6 1912 Dr F M Smith
REGISTRAR

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*, *Sar-*

coma, 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.)



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

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

County Wright
 Township Boone
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 909 File No. 22113
 Primary Registration District No. 6224 Registered No. 7

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

FULL NAME Benjamin Harrison Todd.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH: May 26, 1912
 (Month) (Day) (Year)

DATE OF BIRTH: Aug. 13, 1888
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 4, 1912, to May 26, 1912, that I last saw him alive on May 14, 1912, and that death occurred, on the date stated above, at 8 P. m.

AGE: 23 yrs. 9 mos. 13 ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer): "

Abscess of stomache,
Chronic Pulmonia of first
so says two Physicians
who treated him
 (Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory Excessive ball playing
Excessiv (Duration) 1 yrs. Probab mos. _____ ds.

NAME OF FATHER: John B. Todd

(Signed) R. H. Hanson M. D.

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

May 29, 1912 (Address) Hartsville Mo.

MAIDEN NAME OF MOTHER: Martha C. Newton

*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): Mo.

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) R. E. Todd

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

(ADDRESS) Odin

Former or usual residence _____

Filed Jul 11, 1912 R. E. Todd REGISTRAR

PLACE OF BURIAL OR REMOVAL: Mt. Zion DATE OF BURIAL: May 28, 1912

UNDERTAKER: Pat. Wheelchel ADDRESS: Hartsville

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

Revised United States Standard Certificate of Death

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

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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.)