

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

PLACE OF DEATH

County Dade

Township Centers

Village Wrensfield

City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 237

File No. 29138

Primary Registration District No. 4144

Registered No. \_\_\_\_\_

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

FULL NAME Chas W Barnes

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 22 1912  
(Month) (Day) (Year)

AGE 62 yrs. 2 mos. 2 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Miller  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 9-0

BIRTHPLACE (City or town, State or foreign country) hogan Co Ky

PARENTS  
NAME OF FATHER William Barnes  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky  
MAIDEN NAME OF MOTHER Don't know  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Denton

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John Parlier

(ADDRESS) Greenfield Mo

Filed Sept 24 1912 R. W. Taylor REGISTRAR

2) MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 21 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8-2, 1912, to 9-21, 1912, that I last saw him alive on Sept 21, 1912, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows:  
Cancer  
572  
53E H H  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) Geo. L. Noy M.D.  
9-23 1912 (Address) Greenfield 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 Greenfield Mo DATE OF BURIAL Sept 22 1912

UNDERTAKER Hugh Harrison ADDRESS Greenfield Mo

... WITH UNFADING INK—THIS IS A PERM...

... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is...

**PLACE OF DEATH**

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

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

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

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 \_\_\_\_\_

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

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_ and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

Contributory \_\_\_\_\_ (SECONDARY) \_\_\_\_\_ (Signed) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

\*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) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ State \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ At place of death \_\_\_\_\_ 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 \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITE PLAIN. MARGIN RESERVED FOR BINDING

N. B.—Every item of information given, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

Wm. J. Blair Greenfield

PLACE OF DEATH

County Dade  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_

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

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

Registration District No. \_\_\_\_\_ File No. 29138  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME

Chas W Barber

St.: \_\_\_\_\_ Ward \_\_\_\_\_

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____		
(Month) _____ (Day) _____ (Year) _____		
AGE _____		
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) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_, 1919  
(Month) 9 (Day) 21 (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Game of hide & seek  
face & neck  
1 yr. 4 mo. (Duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Signed) Geo P New M. D.  
Jan 9, 19113 (Address) Greenfield

\*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) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

SUPPLEMENTARY

Sept 21

# 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.)