

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

PLACE OF DEATH
County Reynolds.
Township Prebb
or
Village X
or
City X (NO. _____) St. _____ Ward _____

Registration District No. 1108 File No. 8 30563a
Primary Registration District No. 5983 Registered No. 8

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

FULL NAME William Albert Farris

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)

DATE OF BIRTH Nov. 13, 1840
(Month) (Day) (Year)

AGE 71 yrs. 10 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Famer, & miller in farm days
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

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

PARENTS
NAME OF FATHER Lucien A. Farris
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
MAIDEN NAME OF MOTHER Nancy Hyatt
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Farris

(ADDRESS) _____
Filed Sept 24, 1912 W. A. Farris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 21st, 1912
(Month) (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 9 P. m.

The CAUSE OF DEATH was as follows:
Old age and Lung trouble after Effect of measles.

Contributory W. A. Farris
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) had no _____ M. D.
(Address) _____

*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 Buffington Centy DATE OF BURIAL Sept 24, 1912
UNDERTAKER W. A. Farris ADDRESS Redford

INK—THIS IS A PER... N. B.—E... CAUSE...

PLACE OF DEATH

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

County _____

Township _____ File No. _____

or Village _____ Primary Registration District No. _____ Registered No. _____

or 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) _____ (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 _____ (Month) _____ (Day) _____, 191_____ (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:

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

Contributory
(SECONDARY)

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

(Signed) _____ (Address) _____ M. D.

*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 _____, 191_____

UNDERTAKER _____ ADDRESS _____

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 Reynolds
Township Webb
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1108 File No. 30563-9
Primary Registration District No. 5983 Registered No. 8

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

FULL NAME William Albert Farris

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
DATE OF BIRTH Nov. 13, 1840
(Month) (Day) (Year)
AGE 71 yrs. 10 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work Farmer + miller
(b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE (City or town, State or foreign country) Mo. Redford

PARENTS
NAME OF FATHER Lucas Farris
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
MAIDEN NAME OF MOTHER Nancy Hyatt
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. A. Farris
(ADDRESS) Redford Mo.
Filed SEP 24 1912 G. A. Farris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 21, 1912
(Month) (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 90 m.

The CAUSE OF DEATH* was as follows:
Old age + lung trouble after effect of measles
last illness gradually failed in strength (Duration) yrs. 6 mos. _____ ds.
Contributory G. A. Farris (Duration) yrs. _____ mos. _____ ds.
(Signed) Had no Op at all. Was not Sick just knew weaker. M. D.

*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 Buffington Cem DATE OF BURIAL Sept. 24, 1912
UNDERTAKER Wm. Bramly ADDRESS Redford

Original file, date Sept. 24 1912 All information called for must be written on this Supplementary Certificate.

WRITE PLAINLY, WITH UNFADING INK. PRINT IN PLAIN TERMS. PHYSICIANS SHOULD STATE OCCUPATION IN VERY IMPORT...

N. B. G. A. L. Item of information should be carefully supplied in plain terms, so that it may be intelligible to the general public. If the name of the deceased is not known, the name of the informant should be given. If the name of the informant is not known, the name of the registrar should be given. If the name of the registrar is not known, the name of the physician should be given. If the name of the physician is not known, the name of the hospital or institution should be given. If the name of the hospital or institution is not known, the name of the street and number should be given. If the name of the street and number is not known, the name of the ward should be given. If the name of the ward is not known, the name of the city should be given. If the name of the city is not known, the name of the county should be given. If the name of the county is not known, the name of the state should be given. If the name of the state is not known, the name of the country should be given. If the name of the country is not known, the name of the world should be given.

Supplementary

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.)