

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 Stoddard ✓
Township Duck Creek Registration District No. 840 File No. 31769
or
Village _____ Primary Registration District No. 6102 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 Ottis Bates

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Sept 5</u> , 191 <u>2</u> (Month) (Day) (Year)
DATE OF BIRTH _____, _____, _____ (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from <u>Sept 5</u> , 191 <u>2</u> , to <u>Sept 5</u> , 191 <u>2</u> , that I last saw him alive on <u>Sept 5</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>9 P.</u> m.	
AGE _____, _____, _____ yrs. mos. ds.	If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Congestive typhus of malaria</u> <u>38</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>John W Bates</u>	(Signed) <u>L. B. Burr</u> M. D. <u>Sept 6</u> , 191 <u>2</u> (Address) <u>Duck Creek</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>State of Ky</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER <u>Myrtle Redford</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>State of Ky</u>	At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>O. R. Redford</u>		Where was disease contracted if not at place of death? _____ Former or usual residence _____	
(ADDRESS) _____		PLACE OF BURIAL OR REMOVAL <u>Fair View Cemetery</u>	DATE OF BURIAL <u>9/6</u> , 191 <u>2</u>
Filed <u>Sept 5</u> , 191 <u>2</u> <u>L. B. Burr</u> REGISTRAR	UNDERTAKER <u>J. A. Hickman</u>		ADDRESS <u>Duck Creek Mo</u>

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.)



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

PLACE OF DEATH

County Stoddard
 Township Duck Creek
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

Registration District No. 840 File No. _____
 Primary Registration District No. 6102 Registered No. _____

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

FULL NAME Ottis Bates

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE, <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>X</u>
DATE OF BIRTH _____ (Month) (Day) (Year)		
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) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 5, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 3, 1912, to Sept. 5, 1912
 that I last saw him alive on Sept. 5, 1912
 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:
Congestive typhoid
of malarial

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

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

(Signed) L. Burris M. D.
Sept. 6, 1912 (Address) Pepico, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Fairview Cem. DATE OF BURIAL 9/6, 1912

Filed Sept 5, 1912 L. Burris
 REGISTRAR

UNDERTAKER J.A. Hiskman ADDRESS Pepico, Mo.

SEP

INFORMATION SHOULD BE FULLY SUPPLIED AND SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

WRITE

Revised United States Standard Certificate of Death

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