

Copies from Kentucky certificate

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

PLACE OF DEATH

County Mississippi  
Township James Bayou  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 1051 File No. 33543  
Primary Registration District No. 5768 Registered No. \_\_\_\_\_

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

FULL NAME Ferd Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Aug. 27, 1912  
(Month) (Day) (Year)  
AGE 1 yrs. 1 mos. ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) (2)

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

PARENTS  
NAME OF FATHER Ferd Barnes  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.  
MAIDEN NAME OF MOTHER Velva Ray  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Ferd Barnes  
(ADDRESS) Dorma Mo.

Filed Oct. 12, 1912 Isaac Elder REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 12, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 12, 1912, to \_\_\_\_\_, 1912, that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 1912, and that death occurred, on the date stated above, at 10 A.M.  
The CAUSE OF DEATH\* was as follows:

Cholera Infantum  
119A  
(Duration) 1 yrs. 20 mos. ds.

Contributory \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J.M. Hubbard M. D.  
Oct 12, 1912 (Address) Hickman Ky.

\*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 Sugar Tree Ridge DATE OF BURIAL Oct. 13, 1912  
UNDERTAKER Hickman Fun. Co. ADDRESS Hickman Ky.

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.

IS A PERMANENT RECORD  
PLAINLY, WITH UNFADING INK

# 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.)

Commonwealth of Kentucky

STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH

CERTIFICATE OF DEATH

County *Mississippi*

File No. *2*

Dr. *James Bayne*

Registration District No. *105-1*

Registered No. *5-768*

Ino. Town

Primary Registration District No. *5968*

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

City

(No.

St.,

Ward)

2 FULL NAME *Ferd Barnes*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

*24 May, 1912*  
(Month) (Day) (Year)

7 AGE

*1* yrs. *1* mos. *0* ds.

IF LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION

Trade, profession, or particular kind of work

*Furnace*

(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Mo.*

10 NAME OF FATHER

*Ferd Barnes*

11 BIRTHPLACE OF FATHER (State or country)

*Mo.*

12 MAIDEN NAME OF MOTHER

*Viola Ray*

13 BIRTHPLACE OF MOTHER (State or country)

*Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ferd Barnes*

(Address) *Leon Mo.*

15

Filed *Oct 12, 1912*

*I He Leon*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Oct 12, 1912*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased

from *Oct 12*, 191*2*, to *—*, 191*1*,

that I last saw h. *—* alive on *—*, 191*1*,

and that death occurred on the date stated above at *1 P. M.* The CAUSE OF DEATH\* was as follows:

*Cholera Infantis*

(Duration) *—* yrs. *—* mos. *20* ds.

Contributory (SECONDARY)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *J. M. Hubbard*, M. D.

*Oct 12, 1912* (Address) *Victoria St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 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 *—*

19 PLACE OF BURIAL OR REMOVAL

*Super Friends*

DATE OF BURIAL

*Oct 13, 1912*

20 UNDERTAKER

*Hickman Fun. Co.*

ADDRESS

*Hickman City*

THIS INFORMATION SHOULD BE CAREFULLY SUPPLIED AND 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. SEE INSTRUCTIONS ON BACK.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

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

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NOTE—Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyæmia, septicæmia, tetanus.

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