

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

Washington
Belgrade

Registration District No. 885 File No. 3970

Primary Registration District No. 6183 Registered No.

Village or City (NO. St. Ward)

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

FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Jan 5, 1913 (Month) (Day) (Year)

AGE one hour 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) Belgrade Mo

PARENTS NAME OF FATHER Rodney J. Weckinsor BIRTHPLACE OF FATHER Palmer mo MAIDEN NAME OF MOTHER Edith Byrd BIRTHPLACE OF MOTHER Beulah Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. W. Robinson (ADDRESS) Belgrade Mo

Filed Jan 8, 1913 J. A. Eaton REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 3, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 5, 1913, to Jan 5, 1913, that I last saw him alive on Jan 5, 1913,

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows: Insanitation 1 1/2 hrs. (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) J. W. Robinson M. D. 115, 1913 (Address) Belgrade 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 Bryan County DATE OF BURIAL Jan 6, 1913 UNDEBTAKER A Byrd ADDRESS Belgrade Mo

PHYSICIAN'S SIGNATURE AND RESIDENCE

EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT

PLACE OF DEATH

**MISSOURI STATE BUREAU OF VITALS
CERTIFICATE OF DEATH**

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____) _____ St.; _____ Ward)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

death occurred
 hospital or institution
 Give its NAME and number
 of street and number

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (If rife 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 _____, 191____, _____
 (Month) _____ (Day) _____ (Year)
 I HEREBY CERTIFY, that I attended deceased prior
 to _____, 191____, to _____, 191____,
 that I last saw h_____ alive on _____, 191____,
 and that death occurred, on the date stated above, at _____
 The CAUSE OF DEATH* was as follows:

Contributory _____
 (secondary)
 (Signed) _____, 191____ (Address) _____
 _____, 191____ (Address) _____
 _____, 191____ (Address) _____
 _____, 191____ (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. 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 _____
 UNDERTAKER _____ ADDRESS _____

NS should state very important.

PLACE OF BIRTH

County Washington
Township Belgrade
or
Village
or
City

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

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

Registration District No. 888 File No. _____
Primary Registration District No. 6183 Registered No. _____
(NO. _____ St. _____ Ward _____)

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

FULL NAME

Not named Wilkinson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED. (Write the word) S
DATE OF BIRTH Jan 5, 1913
(Month) (Day) (Year)
AGE _____ IF LESS than 1 day, _____ hrs. or _____ min. _____ 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) _____

DATE OF DEATH Jan 5, 1913
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Jan 5, 1913, to Jan 5, 1913, that I last saw h _____ alive on _____, 1913, and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Inanition & Premature birth.

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

PARENTS
NAME OF FATHER Sidney Wilkinson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Calmer Mo
MAIDEN NAME OF MOTHER Esther Byrd
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

Contributory _____ (SECONDARY) _____ (Duration) yrs. _____ mos. _____ ds.
(Signed) J. D. Robinson, M. D. 3/10/13 (Address) Belgrade Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Robinson
(ADDRESS) Belgrade 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 _____

Filed Jan 8 1913 J. H. Eaton X REGISTRAR

PLACE OF BURIAL OR REMOVAL Bryan Cem DATE OF BURIAL Jan 6, 1913
UNDERTAKER A. Byrd ADDRESS Belgrade Mo

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*, *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.)

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