

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
County Cullaway
Township Guthrie
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 1120 File No. 1 4460
Primary Registration District No. 5162 Registered No. 4

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

FULL NAME Benjamin Franklin Sholey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>widowed</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>June 27, 1836</u> (Month) (Day) (Year)		
AGE <u>76 yrs. 6 mos. 17 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-1-25</u>		
BIRTHPLACE (City or town, State or foreign country) <u>New Bloomfield, Mo.</u>		
PARENTS	NAME OF FATHER <u>Reason Sholey</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Nancy G. White</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14, 1919
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 4, 1919, to Jan 14, 1919, that I last saw him alive on Jan 14, 1919, and that death occurred, on the date stated above, at 10⁴⁵ a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.

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

(Signed) Ernest Rust M. D.
Jan 14, 1919 (Address) New Bloomfield, 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) Ray Holt
(ADDRESS) New Bloomfield
Filed July 8, 1919 J. W. Benton REGISTRAR

PLACE OF BURIAL OR REMOVAL Guthrie
DATE OF BURIAL Jan 16, 1919
UNDERTAKER Ray A. Holt ADDRESS New Bloomfield

A PAPER
PRINTED WITH THE
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 "Asthma," "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.)

PLACE OF DEATH

County

Callaway

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

Township

Guthrie

Registration District No.

1120

File No.

4460

or

Village

Primary Registration District No.

5162

Registered No.

4

City

(NO.

St.

Ward)

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

FULL NAME

Benj. Franklin Shelby

PERSONAL AND STATISTICAL PARTICULARS

SEX

m

COLOR OR RACE

w

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

wd

DATE OF BIRTH

June 27, 1836
(Month) (Day) (Year)

AGE

76 yrs. 6 mos. 17 ds.

If LESS than
1 day, hrs. or mins.

OCCUPATION

(a) Trade, profession, or particular kind of work

farmer

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

BIRTHPLACE

(City or town, State or foreign country)

near New Bloomfield Mo

PARENTS

NAME OF FATHER

Reason Shelby

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

Ky

MAIDEN NAME OF MOTHER

Nancy G. White

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy Holt

(ADDRESS)

New Bloomfield

Filed

Jan 12 1913

REGISTRAR

J. W. Brown

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 14, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 4, 1913, to Jan 14, 1913, that I last saw him alive on Jan 14, 1913.

that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Gobar

Contributory

(SECONDARY)

(Duration) yrs. mos. 10 ds.

(Duration) yrs. mos. ds.

(Signed) E. E. Rusk M.D.

Jan 14, 1913 (Address) New Bloomfield 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

Guthrie

DATE OF BURIAL

Jan 18, 1913

UNDERTAKER

Roy O. Holt

ADDRESS

New Bloomfield

Original file, date

FEB 9 1913

All information called for must be written on this Supplementary Certificate.

PLAIN. WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Revised United States Standard Certificate of Death

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

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