

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Morgan
 or
 Township Morrison
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 598 File No. 10035
 Primary Registration District No. 5792A Registered No. 16

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

FULL NAME

Robert Burns

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>single</u> WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH <u>Mar 24, 1893</u> (Month) (Day) (Year)		
AGE <u>20</u> yrs. <u>5</u> mos. <u>5</u> ds.		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>-1-02</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Morgan Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Alfred Burns</u>	
	BIRTHPLACE OF FATHER <u>Morgan Co. Mo.</u> (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER <u>Nettie Moore</u>	
	BIRTHPLACE OF MOTHER <u>Morgan Co. Mo.</u> (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 29, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 25, 1913, to Mar 29, 1913, that I last saw him alive on Mar 29, 1913, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Sclerosis following
accidental injury to hand
1948 (Duration) _____ yrs. _____ mos. 5 ds.
Contributory injury to hand
(SECONDARY) (Duration) _____ yrs. _____ mos. 20 ds.
(Signed) A. J. Gunn M. D.
Mar 30, 1913 (Address) Versailles 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 Versailles Mo. DATE OF BURIAL Mar 30, 1913

UNDERTAKER Wakilwee ADDRESS Versailles

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Gunn
(ADDRESS) Versailles Mo.

Filed Mar 30, 1913 A. N. Putman REGISTRAR

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

PLACE OF DEATH

County _____ Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 or City _____ (NO. _____) St. _____ Ward _____
 City _____ (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 (If <i>fit</i> , the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____	IF LESS than 1 day, _____ hrs or _____ min.?	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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 _____, Mo.
 The CAUSE OF DEATH* was as follows:

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) _____

Contributory
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____, 191____ (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. 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 _____

Filed _____, 191____, _____ REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Morgan
 Township Morgan
 or Village _____
 or City _____

Registration District No. 598 File No. _____
 Primary Registration District No. 5792B Registered No. 16
 City _____ St. _____ Ward _____

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

FULL NAME

Robert Burns

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Mar. 24, 1893
(Month) (Day) (Year)

AGE 20 yrs. 6 mos. 5 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) _____

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

NAME OF FATHER Alfred Burns

BIRTHPLACE OF FATHER (City or town, State or foreign country) Polk Co. Mo.

MAIDEN NAME OF MOTHER Nettie Moore

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Morgan Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. J. Gunn

(ADDRESS) Versailles, Mo.

Filed Apr 23 1913 A. N. Luman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 29, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 25, 1913 to March 29, 1913, and that I last saw him alive on Mar 29, 1913.

and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:
Petanus following accidental injury to hand.

Contributory Injury to hand
(Duration) yrs. mos. ds.

(Signed) A. J. Gunn M.D.
3-30-1913 (Address) Versailles 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 Versailles DATE OF BURIAL 3-30-1913

UNDERTAKER H. A. Kidwell ADDRESS Versailles

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 date of onset of DISEASE is very important.

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.)

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