

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 Lawrence
 Township Red Oak or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
 Registration District No. 1054 File No. 13629
 Primary Registration District No. 5631 Registered No. 21

FULL NAME Robert John Spencer

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>
DATE OF BIRTH <u>March 24</u> , 18 <u>48</u> <small>(Month) (Day) (Year)</small>		
AGE <u>65</u> yrs. <u>1</u> mos. <u>1</u> ds.		if LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-0-2</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 25, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1912, to Apr 25, 1913
 that I last saw him alive on Apr 10, 1913
 and that death occurred, on the date stated above, at 6 P.M.
 The CAUSE OF DEATH* was as follows: 1-0-2

Pneumonia following
 (Duration) ___ yrs. 3 mos. ___ ds.

BIRTHPLACE
 (City or town, State or foreign country) Kentucky

PARENTS	NAME OF FATHER <u>Robert J. Spencer</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>
	MAIDEN NAME OF MOTHER <u>Lottie Cubink</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>

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

(Signed) C. J. Overstump M. D.
Apr 25, 1913 (Address) Red Oak

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. L. Spencer
 (ADDRESS) Miller Mo.

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 April 28, 1913 Wm Weber
 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Loss Cove</u>	DATE OF BURIAL <u>July 4/26</u> , 19 <u>13</u>
UNDERTAKER <u>John Neely</u>	ADDRESS <u>Miller 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 surgi al 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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Lawrence

Township Red Oak

or Village _____

or City _____

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

Registration District No. 1054

File No. 1

Primary Registration District No. 5631

Registered No. 21

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

FULL NAME

Robert John Spencer

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE w MARRIED OR DIVORCED (Write the word) _____

DATE OF BIRTH March 24, 1848
(Month) (Day) (Year)

AGE 65 yrs. 1 mos. 1 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) _____

PARENTS 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) Satisfactory Information Supplied.

(ADDRESS) _____

Filed April 20, 1913 Wm Weber X

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 25, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 1, 1913 to Apr. 25, 1913, that I last saw him alive on 4 10, 1913, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Empyema following
lobar pneumonia

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) W. J. Overstreet M. D. April 26, 1913, (Address) Red Oak

*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 Graves Cem. Gretna DATE OF BURIAL 4/26, 1913

UNDERTAKER John Neely ADDRESS Miller Mo.

SUPPLEMENTARY

91

WRITE BY INFORMATION SHOWN. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE OCCUPATION IS VERY IMPORTANT. BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

Revised United States Standard Certificate of Death

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

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