

PLACE OF DEATH

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

of Ralls Center

Registration District No. *72.5* File No. *14151*

Primary Registration District No. *5156* Registered No. *77*

(NO. _____ St. _____ Ward) _____

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

FULL NAME *William E. Bartrum*

PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE *White* SINGLE MARRIED *Married*
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH *Oct 5 1846*
(Month) (Day) (Year)

AGE *86* yrs. *11* mos. *22* ds. IF LESS than 1 day: ___ hrs. or ___ min.?

PROFESSION OR KIND OF WORK *Farmer*
NATURE OF INDUSTRY, OR ESTABLISHMENT IN WHICH EMPLOYED (or employer) *1-02*

PLACE OF BIRTH (Country) *Ralls Co. Mo.*

NAME OF FATHER *J. P. Bartrum*

PLACE OF BIRTH OF FATHER (City or town, State or foreign country) *Virginia*

NAME OF MOTHER *Sarah M. Bartrum*

PLACE OF BIRTH OF MOTHER (City or town, State or foreign country) *Kentucky*

DOES THIS DECEASED PERSON BELIEVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Signature) *J. L. Bartrum*

ADDRESS *Center Mo.*

4-13- 1913 *W.P. Birney*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *April 11 1913*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Aug*, 1912, to *April 17*, 1913, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at *11 P.m.*

The CAUSE OF DEATH* was as follows:
Paralysis
82-D
(Duration) ___ yrs. *9* mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) *E. H. Grimes* M. D.
April 12 1913 (Address) *Center 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 *Green Lawn* DATE OF BURIAL *April 13 1913*

UNDERTAKER *J. W. Hulse* ADDRESS *Center Mo.*

PLACE OF DEATH

MISSOURI STATE BUREAU OF CERTIFICATION

County _____ Township _____ or _____ or _____ City _____ (NO. _____) Registration District No. _____ Primary Registration District No. _____ File _____ Res _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write 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) _____	

MEDICAL CERTIFI

DATE OF DEATH _____ (M) _____

I HEREBY CERTIFY _____, 191____, that I last saw h_____ alive on _____ and that death occurred, on the _____ The CAUSE OF DEATH* was : _____

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) _____

(Duration) _____

Contributory (SECONDARY) _____ (Duration) _____

(Signed) _____, 191____ (Address) _____

*State the Disease Causing Death, or (1) Means of Injury; and (2) whether Act

LENGTH OF RESIDENCE (FOR MOST RECENT RESIDENTS) At place of death _____ 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) _____

(ADDRESS) _____

Filed _____ 191____ REGISTRAR

PLACE OF BURIAL OR REMOVAL _____

UNDERTAKER _____

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

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.

PLACE OF DEATH

County Ralls
 Township Center
 or
 Village _____
 or
 City _____ (NO. _____)

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. 725 File No. _____
 Primary Registration District No. 5956 Registered No. 72
 St. _____ Ward _____

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

FULL NAME

William Bartrum

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>m</u>
DATE OF BIRTH <u>Oct 5, 1846</u> (Month) (Day) (Year)		
AGE <u>66</u> yrs. <u>6</u> mos. <u>6</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)		
BIRTHPLACE (City or town, State or foreign country) <u>Ralls Co. Mo</u>		
PARENTS	NAME OF FATHER <u>J. P. Bartrum</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	MAIDEN NAME OF MOTHER <u>Sarah W. Bartrum</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>S. L. Bartram</u> (ADDRESS) <u>Center Mo.</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 11, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 5, 1912, to Apr. 11, 1913, that I last saw him alive on 10 April, 1913, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) 8 yrs. 8 mos. 8 ds.

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

(Signed) A. H. Graves M. D.
April 12, 1913 (Address) Center 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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
 If not at place of death? _____

Former or usual residence Satisfactory Information Supplied

PLACE OF BURIAL St. Louis DATE OF BURIAL 4-13-1913

UNDERTAKER J. J. Hulsey ADDRESS Center Mo.
Satisfactory Information Supplied

Filed 4-13 1913 W. P. Birney REGISTRAR

Original file, date APR 1913

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

Revised United States Standard Certificate of Death

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

14151

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.)