

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 Buchanan
Township DeKalb
or DeKalb Mo.
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 81 File No. 29026
Primary Registration District No. 4749 Registered No. 20

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

FULL NAME Bertram Peel

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 4 17, 1899
(Month) (Day) (Year)

AGE 74 yrs. 5 mos. 7 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-07

BIRTHPLACE (City or town, State or foreign country) (Lincolnshire Co) England

NAME OF FATHER J. W. Peel

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James C. Peel

(ADDRESS) DeKalb Mo.

Filed Sept 25 1933 W. J. Shelton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 24, 1933
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 14, 1933, to Sept. 24, 1933, that I last saw him alive on Sept. 24, 1933, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows: Dilatation and paralysis of the heart.

131 95 B (Duration) ___ yrs. ___ mos. 10 ds.

Contributory Chronic interstitial nephritis (SECONDARY) (Duration) One yrs. ___ mos. ___ ds.

(Signed) J. W. McAdow M. D. Sept. 24, 1933 (Address) DeKalb 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 Engle Creek Cemetery DATE OF BURIAL Sept 25, 1933

UNDERTAKER Swain Douglas ADDRESS Harrison

WRITE PL. LY. W. HEAD. THIS IS AN INHERENT 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 Buchanan REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

County Buchanan Registration District No. 81 File No. 7

Township De Kalb or Village De Kalb Primary Registration District No. 4049 Registered No. 20

City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Benjamin Peel

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)	DATE OF DEATH <u>Sept. 24</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Satisfactory Information Supplied</u> (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 _____ m.	
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.			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) _____			_____ _____ _____	
PARENTS	NAME OF FATHER _____		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		(Signed) _____ M. D.	
	MAIDEN NAME OF MOTHER <u>X Unknown X</u>		_____ _____ (Address) _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>England</u>		*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) <u>X James C. Peel X</u> <u>De Kalb, Mo</u> (ADDRESS) <u>Sept 25 3 W. J. Shelton</u> FILED _____ 191 <u>3</u> REGISTRAR			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 <u>Sugar Creek Cemetery</u>			DATE OF BURIAL <u>Sept 30</u> , 191 <u>3</u>	
UNDER _____ <u>Satisfactory Information Supplied</u> <u>Dwain Douglas</u>			ADDRESS <u>Acckeran Kan</u>	

Original file, date SEP 25 1913, 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]

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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