

## PLACE OF DEATH

County MasonTownship Lyda

Village \_\_\_\_\_

City Atlanta Mo (No. \_\_\_\_\_)MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 526 File No. 89977Primary Registration District No. 4317 Registered No. \_\_\_\_\_St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)FULL NAME Benjamin D. Ketcham

## PERSONAL AND STATISTICAL PARTICULARS

|  |                               |   |
|--|-------------------------------|---|
| SEX<br><u>Male</u>   | COLOR OR RACE<br><u>White</u> | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word)<br><u>Widowed</u> |
| DATE OF BIRTH<br><u>Jan 30, 1882</u><br>(Month) (Day) (Year) |                               |   |
| AGE<br><u>81 yrs. 10 mos. 30 ds.</u>                         |                               | IF LESS than<br>1 day, _____ hrs.<br>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) \_\_\_\_\_BIRTHPLACE  
(City or town, State or foreign country) Ind.

|         |  |
|---------|--|
| PARENTS | NAME OF FATHER<br><u>Samuel Ketcham</u>                                      |
|         | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Ind.</u> |
|         | MAIDEN NAME OF MOTHER<br><u>Sophia Davis</u>                                 |
|         | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Ind.</u> |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Ketcham  
(ADDRESS) Atlanta MoFiled 12-31 1913 J. M. Halliburton  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 29, 1913  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec 24, 1913, to Dec 29, 1913, that I last saw him alive on Dec 28, 1913, and that death occurred, on the date stated above, at 10 m.  
The CAUSE OF DEATH\* was as follows:Lafriq Pneumonia  
11A  
11Y (Duration) 0 yrs. 0 mos. 7 ds.  
162 Contributory Semitivity  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) L. C. Lyda M. D.  
Jan 1, 1914 (Address) Atlanta 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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Udell Iowa DATE OF BURIAL Jan 2, 1914  
UNDERTAKER H. M. Goodding ADDRESS Atlanta Mo

PERMANENT RECORD

N. B.—Every item of information should be given. 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

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

N. B.—Every item of information should be marked **EXACTLY**. **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Statement of OCCUPATION** is very important.

County \_\_\_\_\_ Township \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 or Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward) \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME \_\_\_\_\_

| PERSONAL AND STATISTICAL PARTICULARS                               |   |
|--|---|
| SEX  | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word)   |
| DATE OF BIRTH  | (Month) _____, (Day) _____, 191____ (Year)  |
| AGE  | _____ yrs., _____ mos., _____ ds.<br>If LESS than 1 day, _____ hrs. or _____ min.?  |
| OCCUPATION   | (a) Trade, profession, or particular kind of work _____<br>(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<br>(Informant) _____ |   |
| (ADDRESS) _____  |   |
| Filed _____, 191____   | REGISTRAR _____   |

| MEDICAL CERTIFICATE OF DEATH  |  |
|---|--|
| DATE OF DEATH   | (Month) _____, 191____ (Day) _____, 191____ (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. The CAUSE OF DEATH* was as follows: _____   |  |
| Contributory (SECONDARY)  | (Duration) _____ yrs., _____ mos., _____ ds.                                     |
| (Signed)  | (Duration) _____ yrs., _____ mos., _____ ds. M. D. _____ 191____ (Address) _____ |
| *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)<br>At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.<br>Where was disease contracted if not at place of death? _____<br>Former or usual residence _____ |  |
| PLACE OF BURIAL OR REMOVAL  | DATE OF BURIAL _____, 191____  |
| UNDERTAKER  | ADDRESS _____  |

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

N. B.—Every item of information furnished hereon is carefully supplied. An applicant has stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, and properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH  
County Macon

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

Township \_\_\_\_\_ Registration District No. 526 File No. \_\_\_\_\_  
or  
Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
or  
City Atlanta (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE Widowed  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_  
If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ 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) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_

Filed 12-31-13 191\_\_\_\_  
J. M. H. [Signature]  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12-29-13  
(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.

The CAUSE OF DEATH\* was as follows:  
La Grippe Pneumonia  
Lobar  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Sexuality  
(SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed J. M. H. [Signature] M. D.  
\_\_\_\_\_ 191\_\_\_\_ (Address) Atlanta Ga

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# 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

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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.)