

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 Marion
Township _____
or
Village _____
or
City Hannibal (NO. Leveing Hospital St. 6 Ward)

Registration District No. 577 File No. 40022
Primary Registration District No. 3079 Registered No. 202

FULL NAME Burns Christian

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

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Dec 9, 1913
(Month) (Day) (Year)

DATE OF BIRTH April 23, 1857
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 5, 1913, to Dec 9, 1913, that I last saw him alive on Dec 9, 1913, and that death occurred, on the date stated above, at A M.

AGE 56 yrs. 7 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:
Obstruction of bowels—and operation
127 B
133 C (Duration) ____ yrs. ____ mos. ____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory Adhesions from old abscess (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

BIRTHPLACE (City or town, State or foreign country) Harrisonville Mo

PARENTS NAME OF FATHER John Christian

(Signed) E. H. Bounds M. D. 12-9, 1913 (Address) Hannibal Mo

BIRTHPLACE OF FATHER Scotland

MAIDEN NAME OF MOTHER Ann Bonffel

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Emma B. Christian

At place of death ____ yrs. ____ mos. 43 ds. In the State ____ yrs. ____ mos. ____ ds.

(ADDRESS) Hannibal Mo

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

Filed Dec 10, 1913 M. H. Spru REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL St. Michael's Cemetery DATE OF BURIAL Dec 11, 1913

UNDERTAKER Chas. H. H. Bros. ADDRESS Hannibal

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*," "*Uræmia*," "*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.)

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 Maron

Township _____

Village _____

City Kennel (NO. _____)

Registration District No. 547

Primary Registration District No. 3079

File No. _____

Registered No. 302

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

FULL NAME Bonus Christian

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1913
(Month) (Day) (Year)

DATE OF BIRTH _____, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1913,
that I last saw h. _____ alive on _____, 1913,
and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds. (If LESS than 1 day, hrs. _____ or min. _____)

The CAUSE OF DEATH* was as follows:
Destruction of Bowls & Operation

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) _____

Contributory Adhesions from old abscesses (Duration) _____ yrs. _____ mos. _____ ds.

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) _____

(Signed) E. H. Bouds M.D. 12-9-1913 (Address) Kennel Mo.

*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) _____

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 _____

(ADDRESS) _____ Filled 12/10 1913 E. H. Bouds REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1913 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY CERTIFICATE

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