

No. 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 Oregon  
Township Noble  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

✓

Registration District No. 649 File No. 40225  
Primary Registration District No. 6286 Registered No. 23

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

FULL NAME Hugh Bartlett

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Aug 31</u> , <u>1898</u> <small>(Month) (Day) (Year)</small>		
AGE <u>15</u> yrs. <u>3</u> mos. <u>27</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>Noble Mo</u>		
PARENTS	NAME OF FATHER <u>Hubert Bartlett</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Marshfield Mo</u>	
	MAIDEN NAME OF MOTHER <u>Mary Letchworth</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Marshfield Mo</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>Dec 27</u> , <u>1913</u> <small>(Month) (Day) (Year)</small>
I HEREBY CERTIFY, that I attended deceased from <u>Dec 23</u> , 19 <u>13</u> , to <u>Dec 27</u> , 19 <u>13</u> , that I last saw him live on <u>Dec 21</u> , 19 <u>13</u> , and that death occurred, on the date stated above, at <u>3:40</u> pm. The CAUSE OF DEATH* was as follows: <u>Intestinal Obstruction</u> <u>122B</u>  (Duration) <u>0</u> yrs. <u>0</u> mos. <u>7</u> ds.
Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) <u>James R Davis</u> M. D. <u>Dec 27</u> , 19 <u>13</u> (Address) <u>Noble Mo</u>
*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) James R Davis  
(ADDRESS) Noble Mo  
Filed Dec 27 1913 James R Davis  
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Thomfield Mo</u>	DATE OF BURIAL <u>Dec 28</u> , 19 <u>13</u>
UNDERTAKER <u>Neighborhood</u>	ADDRESS <u>Noble Mo</u>

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 \_\_\_\_\_  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_, St. \_\_\_\_\_ Ward)

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

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) \_\_\_\_\_

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

(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:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

(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)

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

UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK. THIS IS A SUPPLEMENTARY CERTIFICATE.

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

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Franklin  
Township Wells  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 649 File No. \_\_\_\_\_  
Primary Registration District No. 6286 Registered No. 23

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

FULL NAME Hugh Bartlett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE S MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ (If write the word)

DATE OF DEATH Dec 27, 1913  
(Month) (Day) (Year)

DATE OF BIRTH Aug. 31 - 1898.  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 23, 1913, to Dec 27, 1913  
that I last saw him alive on Dec 27, 1913  
and that death occurred, on the date stated above, at 3:25 m.

AGE 15 yrs. 3 mos. 27 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 Furniture Supplier  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

Interstitial Absorption  
was caused by eating  
raw turnips  
(Duration) 0 yrs. 0 mos. 0 ds.

BIRTHPLACE (City or town, State or foreign country) Noble Mo.

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 7 ds.

NAME OF FATHER Anton Bartlett

(Signed) James R. Davis M. D.  
(Address) Noble Mo.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Washfield Mo.

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

MAIDEN NAME OF MOTHER Mrs. DePichant

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

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

At place of death \_\_\_ yrs. 0 mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE [ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) James R. Davis  
(ADDRESS) Noble Mo.

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

Filed 12/27 1913 James R. Davis REGISTRAR

PLACE OF BURIAL OR REMOVAL Thornfield Mo. DATE OF BURIAL Dec 28, 1913

UNDERTAKER Wright ADDRESS Thornfield

# 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, 8 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.)