

COPYABLE 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 Hopkins
Township Current River Registration District No. 210 File No. 5045
or
Village _____ Primary Registration District No. 5986 Registered No. 18
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Gas Newton Moon

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Male</u>	COLOR OR RACE <u>WT</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>November 3, 1884</u> <small>(Month) (Day) (Year)</small>		
AGE <u>68</u> yrs. <u>11</u> mos. <u>12</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>Ark.</u>		
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) _____	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>December 13, 1913</u> <small>(Month) (Day) (Year)</small>	
I HEREBY CERTIFY, that I attended deceased from <u>Dec 3, 1913</u> , to <u>Dec 13, 1913</u> , that I last saw him alive on <u>Dec 3, 1913</u> , and that death occurred, on the date stated above, at <u>7 a. m.</u>	
The CAUSE OF DEATH* was as follows: <u>typhoid</u>	
<u>131</u> <u>97</u>	<u>81</u>
Contributory (SECONDARY) <u>Anterior Sclerosi</u> <small>(Duration) yrs. mos. ds.</small>	
(Signed) <u>B N Robinson</u> M. D. <u>12131, 1913</u> (Address) <u>Dampflau</u>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Scindal, 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 _____	
PLACE OF BURIAL OR REMOVAL <u>Juguan Cemetery</u>	DATE OF BURIAL <u>12-4-</u> 191 <u>3</u>
UNDERTAKER <u>None</u>	ADDRESS <u>None</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Lee
(ADDRESS) Monroe Ark.
Filed 12-3- 1913 G B Johnston
REGISTRAR

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*, *Composer*, *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*, *peritoneum*, 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.)

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

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

County Way
 or
 Township Current River
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 750 File No. _____
 Primary Registration District No. 5986 Registered No. 18

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

FULL NAME Gas. Newton Moore

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M
(If wife 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, to _____, 1913, that I last saw him alive on _____, 1913, and that death occurred, on the date stated above, at _____ m.

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

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 (for employer) _____

hepatic
Chronic
 (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) _____

Contributory Autism sepliosis
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) B. H. Robinson M. D.
 1913, 1913 (Address) _____

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) _____

*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

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 _____

(Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1913

Filed _____ 1913 G. B. Johnson REGISTRAR

UNDERTAKER _____ ADDRESS _____

DEC 1913

Revised United States Standard Certificate of Death

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

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