

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

407

PLACE OF DEATH

County

Carroll

Township

Village

City

Carrollton

Registration District No.

Primary Registration District No.

(NO.)

General Hospital

St. 1 Ward

File No.

Registered No. 13

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

FULL NAME

Homer A Cot

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Single

DATE OF DEATH

Jan 17, 1914

DATE OF BIRTH

1 14 1903

AGE

11 yrs. - 3 ds.

If LESS than 1 day, hrs. or min.?

I HEREBY CERTIFY, that I attended deceased from *Jan 10, 1914*, to *Jan 17, 1914*, that I last saw him alive on *Jan 17 8:40 PM 1914*, and that death occurred, on the date stated above, at *8:40* m.

OCCUPATION

(a) Trade, profession, or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:

Obstruction of the bowels

BIRTHPLACE

(City or town, State or foreign country)

Carroll Co Mo

Contributory

Toxemia

NAME OF FATHER

A N Cot

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

Carroll Co Mo

MAIDEN NAME OF MOTHER

Lela V Barr

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

Carroll Co Mo

(Signed)

A W Hull

M. D.

Jan 17, 1914 (Address) *Carrollton 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. *14* ds. In the State *11* yrs. - mos. *3* ds.

Where was disease contracted if not at place of death? *At Home*

Former or usual residence *Carroll Co. Mo -*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A N Cot

(ADDRESS)

Norborne Mo

PLACE OF BURIAL OR REMOVAL

Beatty Cemetery

DATE OF BURIAL

1-18 1914

UNDERTAKER

Miller Bros

CORRESP

Carrollton Mo

Filed

Jan 17 1914 Mrs E. S. Jamison

REGISTRAR

Filed Jan 17 1914 Wm S Parkins Sub-registrar

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.

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 *septicæmia*," "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.)

PLACE OF DEATH

County Carroll

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

Township _____

Registration District No. 135

File No. _____

Village _____

Primary Registration District No. 3010

Registered No. 13

City Carrollton

NO. General Hosp St. 1 Ward)

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

FULL NAME

Nomer, A. Cox

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 17, 1914
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914, that I last saw h. _____ alive on _____, 1914, and that death occurred, on the date stated above, at _____ p.m.

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

The CAUSE OF DEATH* was as follows:
Obstruction of the bowels
Cause unknown

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) _____

(Duration) _____ yrs _____ mos _____ ds.

NAME OF FATHER _____

Contributors Toxemia
(SECONDARY)

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

(Duration) _____ yrs _____ mos _____ ds.

MAIDEN NAME OF MOTHER _____

(Signed) N. W. Full M. D.
Jan 17, 1914 (Address) Carrollton, Mo

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
(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) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1914

Filed 17, 1914 Mrs. E. E. Farabee REGISTRAR

UNDERTAKER _____ ADDRESS _____

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.

JAN - -1914

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205
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