

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

PLACE OF DEATH

County Legas
Township Harold
or
Village Licking
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 868 File No. 36411
Primary Registration District No. 6149 Registered No. 2

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

FULL NAME David T. Collier

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept. 1, 1836
(Month) (Day) (Year)

AGE 77 yrs. 4 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Pop. Tenn.

PARENTS
NAME OF FATHER Jessie Collier
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
MAIDEN NAME OF MOTHER Maholia Ellie
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D. Collier
(ADDRESS) Licking Mo

Filed Jan 4, 1914 W. R. Reid
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 4, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 24, 1913, to Jan 4, 1914, that I last saw h alive on Jan 4, 1914, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Nephritis
23A
131

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Breaking of ribs
(Secondary) in lungs (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Leslie Randall M. D.
Jan 4, 1914 (Address) Licking 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 State ___ yrs. ___ mos. ___ ds.
Where was disease contracted If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Licking Cemetery DATE OF BURIAL Jan 5, 1914
UNDERTAKER Cameron & Co ADDRESS Licking Mo

B- Every item on this form should be filled in, unless otherwise indicated. If the cause of death is not properly classified, Exact CAUSE OF DEATH in plain language should be given.

Revised United States 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 "*Asithenia*," "*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.)

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

PHYSICIANS should state EXACT OPERATION is very important. CAUSE OF DEATH should be stated EXACTLY classified. EXACT statement of

MISSOURI STATE BOARD OF HEALTH

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

PLACE OF DEATH Texas
 County Sherrill Registration District No. 868 File No. _____
 Township _____ or Village _____ Primary Registration District No. 6149 Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME David T. Collier (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OF RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
 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) _____
 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) _____

DATE OF DEATH Jan. 4, 1914
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:
Respiritis (Chronic)
78
 Contributory Breaking of a knee
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. D. Lickens, M. D.
1-4-14 (Address) Licking, Mo.

SUPPLEMENTARY CERTIFICATE

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed Jan 4 1914 REGISTRAR W. P. [Signature]

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 _____ 1914
 UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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