

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

County Lincoln Registration District No. 491 File No. 5316
Township _____ or _____ Village _____ or _____ City Froy (NO. _____ St. _____ Ward _____)
FULL NAME Benjamin Elliott Bull (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widower</u> (Write the word)
DATE OF BIRTH <u>July 8, 1820</u> (Month) (Day) (Year)		
AGE <u>94</u> yrs. <u>17</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>92nd Genility, Heart Disease</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Virginia</u>		
PARENTS	NAME OF FATHER <u>Sheltie Bull</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	MAIDEN NAME OF MOTHER <u>Mary Elliott</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 25, 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from July 1st, 1914, to July 25, 1914, that I last saw him alive on July 25, 1914, and that death occurred, on the date stated above, at 12¹⁵ m. The CAUSE OF DEATH* was as follows:
92nd Genility, Heart Disease

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. P. Smith M. D. July 25, 1914 (Address) Froy 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) JR Bull
(ADDRESS) Froy Mo
Filed July 25, 1914. SRM Kay REGISTRAR

PLACE OF BURIAL OR REMOVAL Froy Mo DATE OF BURIAL July 26, 1914
UNDERTAKER E. A. Kemper ADDRESS Froy Mo

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

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," "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.)

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Linn Registration District No. 491 File No. 7
 Township _____ or _____ Village Tray Primary Registration District No. 4298 Registered No. 7
 City _____ (NO. _____) St.: _____ Ward _____

FULL NAME B. Elliott Bull

[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 <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>W</u> (Write the word)	DATE OF DEATH <u>7/25</u> , 191 <u>4</u> (Month) (Day) (Year)
DATE OF BIRTH _____ (Month) (Day) (Year)	AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.		HEREBY CERTIFY, that I attended deceased from _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at <u>12th</u> m.
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____	The CAUSE OF DEATH* was as follows: <u>Senility & Strabismus</u> <u>Mitral Regurgitation</u>		
BIRTHPLACE (City or town, State or foreign country) _____	(Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER _____	Contrabitory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	(Signed) <u>Wm P Smith</u> M. D. <u>7/25</u> , 191 <u>4</u> (Address) <u>Tray 9th</u>	
	MAIDEN NAME OF MOTHER _____	*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) _____	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>Tray</u> , _____ mos. _____ ds. 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) _____ (ADDRESS) _____			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
Filed <u>7/25</u> , 191 <u>4</u> <u>Wm P Smith</u> REGISTRAR <u>3/25, 1914</u>			UNDERTAKER _____ ADDRESS _____

Original file, date _____, 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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