N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, and 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 Ozark

Township Bayou
or
Village
or
City (NO. , St.; Ward)

Registration District No. 647 File No. 16854

Primary Registration District No. 5867 Registered No.

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

FULL NAME not named

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May (Month) 19 (Day), 1914 (Year)

AGE 0 yrs. 0 mos. 0 ds. | If LESS than 1 day, 0 hrs. or 30 min.?

OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —

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

PARENTS
NAME OF FATHER Benj. F. Atkinson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Webster Co. Mo.
MAIDEN NAME OF MOTHER Clara C. Isom
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ozark Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara C. Atkinson

(ADDRESS) Bakersfield, Mo.

Filed May 25, 1914 L W Lawson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 19 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 19, 1914, to May 19, 1914, that I last saw him alive on May 19, 1914, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

151

— (Duration) — yrs. — mos. — ds.

Contributory (SECONDARY) —

— (Duration) — yrs. — mos. — ds.

(Signed) W. T. Wiles M. D.

May 19, 1914 (Address) Bakersfield, 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 | DATE OF BURIAL ___, 191__

UNDERTAKER | ADDRESS

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 providedfor 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 *septichaemia*," "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.)

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.

PLACE OF DEATH

County Ozark

Township Bryon

or

Village

or

City (NO. , St.; Ward)

Registration District No. 647 File No.

Primary Registration District No. 5857 Registered No. 10

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

FULL NAME Unnamed Atkinson.

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

DATE OF BIRTH , 1 (Month) (Day) (Year)

Satisfactory Information Supplied.

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)

Satisfactory Information Supplied.

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed May 25 1914 L W Lawson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 19 1914 (Month) (Day) (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.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Satisfactory Information Supplied.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

Satisfactory Information Supplied.

(Signed)

, 191 (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
Bakersfield Cemetery	May 20 1914
UNDERTAKER	**ADDRESS**
A W Morris	Bakersfield

SUPPLEMENTARY

Original file, date MAY 1914, 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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