

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

PLACE OF DEATH
County Ripley
Township Dumpham
or R.F.D. No. 1
Village _____
or _____
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 753 File No. 26308
Primary Registration District No. 5985 Registered No. 60

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

FULL NAME Floto Arnold

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH March 23, 1914
(Month) (Day) (Year)
AGE 2 yrs. 22 mos. 22 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH June 14, 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from June 11, 1914, to June 14, 1914, that I last saw him alive on June 14, 1914 and that death occurred, on the date stated above, at 8:20 pm.

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:
Acute Ectherich's

BIRTHPLACE R.F.D. No. 1 Ripley Co. Mo.
(City or town, State or foreign country)

(Duration) ___ yrs. ___ mos. 5 ds.
Contributory meningitis
(SECONDARY) (Duration) ___ yrs. ___ mos. 1 ds.

PARENTS
NAME OF FATHER Chester C Arnold
BIRTHPLACE OF FATHER Ripley Co. Mo.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Myrtle Floto
BIRTHPLACE OF MOTHER Lackwood Mo.
(City or town, State or foreign country)

(Signed) A. C. Priddy M. D.
June 15, 1914 (Address) Dumpham

*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) Chester C Arnold
R.F.D. No. 1 Dumpham
(ADDRESS)

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 _____

Filed 6-15- 1914 E. B. Johnson
REGISTRAR

PLACE OF BURIAL OR REMOVAL mo. Sullwan Conference
DATE OF BURIAL June 15, 1914
UNDERTAKER J. R. Wright ADDRESS Dumpham 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.

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, 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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Ripley
Township or Village Comphau
City _____

Registration District No. 750 File No. _____
Primary Registration District No. 5985 Registered No. 60
St. _____ Ward _____

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

FULL NAME John Arnold

PERSONAL AND STATISTICAL PARTICULARS

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

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 (if employer) _____

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

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 6/15 1914 W. B. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 14 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____
satisfactory information supplied _____, 191____,
that I last saw him _____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Heart failure
Cent. Enterocolitis

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory Measles
(SECONDARY) (Duration) _____ yrs. _____ mos. 1 ds.
(Signed) W. B. Johnson M. D.
June 15 1914 (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. 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]

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