

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

PLACE OF DEATH
County Jackson
Township _____ or _____
Village _____ or _____
City Carthage (NO. 3020 Main & Chestnut St. _____ Ward _____)
Registration District No. 408 File No. 22971
Primary Registration District No. _____ Registered No. 115
FULL NAME Thomas Arthur M^o Murtry (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>Married</u> (Write the word)
DATE OF BIRTH <u>Dec 29</u> , 19 <u>4</u> (Month) (Day) (Year)		
AGE <u>42</u> yrs. ____ mos. ____ ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Physician</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Kansas City Mo</u>		
PARENTS	NAME OF FATHER <u>J. B. M^o Murtry</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Jackson Co Mo</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth M^o Cubbin</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 194
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from June 23, 194, to July 12, 194, that I last saw him alive on July 12, 194, and that death occurred, on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:

Two Kidneys (Double)

25 (Duration) yrs. ____ mos. ____ ds.
Contributory Abdominal Rupture
(SECONDARY) (Duration) yrs. ____ mos. ____ ds.
(Signed) David J. Fine M. D.
July 12 1914 (Address) Carthage 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 Missouri

PLACE OF BURIAL OR REMOVAL Lawrence Mo. DATE OF BURIAL July 15, 194
UNDERTAKER Knell and Co. Carthage Mo. ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth M^o Murtry
(ADDRESS) Carthage Mo
Filed July 13, 194, W. E. State 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 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.)

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.

PLACE OF BIRTH

Jasper

County

Township

Village

City

FULL NAME

Thomas Arthur Mc Mentry

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

Registration District No.

408

File No.

Primary Registration District No.

3020

Registered No.

115

St.

Ward

(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 (Write the word)

Married

DATE OF DEATH

July 12, 1914

DATE OF BIRTH

Satisfactory information supplied

AGE

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)

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

Dec 7 1914

W. Seale

REGISTRAR

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ on _____, 191____, and that death occurred, on the _____ stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Res. Kidneys Doubtful due to Tuberculosis (Duration) 3 yrs. mos. ds. Contributory Abdominal Rupture (Duration) 3 yrs. mos. ds. Signed David C. Gipe, M.D. July 12, 1914 (Address) Carthage Mo.

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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

UNDERTAKER

ADDRESS

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory information supplied

Original file, date JUL - 1914

All information called for

Revised United States Standard Certificate of Death

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

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