

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

PLACE OF DEATH

County New Madrid
Township West
or
Village Canalou
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 1139 File No. 23409
Primary Registration District No. 4537 Registered No. 6

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

FULL NAME Not Named - Gibson

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)

DATE OF BIRTH June 27, 1914
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 12 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
NAME OF FATHER C O Gibson
BIRTHPLACE OF FATHER Mo.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Della Taylor
BIRTHPLACE OF MOTHER Mo.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C O Gibson
(ADDRESS) Canalou Mo

Filed 7-8- 1914 J. W. Baughman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 9th, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 8, 1914, to July 9, 1914, that I last saw her alive on July 4th, 1914, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:
Congenital Stelectasis

16 1/2 (Duration) yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) yrs. _____ mos. _____ ds.
(Signed) Chauncy M. Stokes M. D.
7-9 1914 (Address) Canalou 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 Stokeup Graveyard DATE OF BURIAL 7-10-1914
UNDERTAKER Albritton ADDRESS Stokeup

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 "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 New Madrid
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1133 File No. _____
 Primary Registration District No. 4587 Registered No. 6

FULL NAME Unnamed Gibson

[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 OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH July 9, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw him alive on _____, 191____,

AGE _____
If LESS than 1 day, ____ hrs. or ____ min. 2 yrs. ____ mos.

and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

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

Congenital Atelectasis and Deficient Oxygenation
(Duration) ____ mos. 12 ds.

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

Contributory _____
(Secondary) (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Chauncey M. Stokes M.D.
719 (Address) Carroll Ave.

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) _____

*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) _____
 (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 _____ 1914
J. W. Baughman
 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

Be stated EXACTLY. PHYSICIANS should state as fully as possible. Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

50472

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