

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

PLACE OF DEATH

County Wallas

Township South Benton

Village _____

City _____

Registration District No. 241

File No. 25714

Primary Registration District No. 5334

Registered No. 111

FULL NAME John C. Rapin

(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 male COLOR OR RACE white SINGLE—
MARRIED—
WIDOWED—
OR DIVORCED—
(Write the word) widowed

DATE OF DEATH June 21, 1914
(Month) (Day) (Year)

DATE OF BIRTH Apr 10, 1825
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 25, 1914, to June 8, 1914, that I last saw him alive on June 8, 1914, and that death occurred, on the date stated above, at 5 P.M.

AGE 89 yrs. 2 mos. 11 ds. IF LESS than
1 day, ____ hrs.
or ____ min.?

The CAUSE OF DEATH* was as follows:
Bright's - of
Heart - trouble

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

(Duration) 1 yrs. 6 mos. ____ ds.

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

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

NAME OF FATHER J. C. Rapin

(Signed) B. F. Johnson M. D.
June 21, 1914 (Address) Buffalo, Mo.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky

*State the Disease causing Death, or, in death from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER Anna Mulkey

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

Where was disease contracted if not at place of death? _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Geo Rapin

Former or usual residence _____

(ADDRESS) Buffalo, Mo.

PLACE OF BURIAL OR REMOVAL Bruce frame cndy DATE OF BURIAL June 21, 1914

Filed Aug 1, 1914 J. Pallis REGISTRAR

UNDERTAKER William & Newport ADDRESS Buffalo 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*, *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, 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.)

EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

PLACE OF DEATH

County Gallatin
Township S. Benton
or
Village
or
City

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

Registration District No. 241 File No. _____
Primary Registration District No. 61334 Registered No. 111

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

FULL NAME

John C Roper

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> <small>(Write the word)</small>
DATE OF BIRTH <u>Satisfactory Information Supplied.</u>		
AGE <u>Satisfactory Information Supplied.</u>		
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)		
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)	

DATE OF DEATH June 21, 1914
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Bright's Heart Trouble
Disease
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) 170
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) 6-21-14 (Address) Buffalo Mo

SUPPLEMENTARY INFORMATION SUPPLIED.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory Information Supplied.

(ADDRESS) _____
Filed Aug 1, 1914 J. Phillips REGISTRAR

*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 <u>Satisfactory Information Supplied.</u>	DATE OF BURIAL _____ 191____
UNDERTAKER	ADDRESS

AUG 1914

Revised United States Standard Certificate of Death

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

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FILED