

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

31162

PLACE OF DEATH
County Stoddard
Township Pipe
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 835 File No. _____
Primary Registration District No. 1098 Registered No. _____

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

FULL NAME Raymond Coke

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH 9 14, 1914
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from 9/13, 1913, to 9/14, 1914,
that I last saw him alive on 9/13, 1914,
and that death occurred, on the date stated above, at 4 A. m.

AGE 34 If LESS than 1 day, ____ hrs. or ____ min.?
yrs. mos. ds.

The CAUSE OF DEATH* was as follows:
Benign Malaria
3 2
04
(Duration) yrs. mos. ds.

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

BIRTHPLACE (City or town, State or foreign country) Near Bell City, Mo.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
(Signed) C.O. Bennett M. D.
9/14, 1914 (Address) Bell City, Mo.

PARENTS NAME OF FATHER Frank Coke

BIRTHPLACE OF FATHER (City or town, State or foreign country) Coles Co., Ill.

MAIDEN NAME OF MOTHER Ella Kittle

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

*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) Frank Coke
(ADDRESS) Bell City, Mo.

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 _____

Filed _____, 191____ 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 "Asthensia," "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.)

County Stoddard Registration District No. 835 File No. 1
 Township Pike or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
 Primary Registration District No. 6099 Registered No. 1

FULL NAME Raymond Coke

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF RACE W SINGLE Single MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH was not recorded (Month) (Day) (Year)
 AGE _____ If LESS than 1 day, _____ hrs. or _____ min. _____ yrs. _____ mos. _____ ds.
 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) Bell city Mo

PARENTS

NAME OF FATHER	<u>Frank B. Coke</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country)	<u>Ill</u>
MAIDEN NAME OF MOTHER	<u>Ella Nittler</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<u>Ill</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank B. Coke
 (ADDRESS) Bell City Mo

Filed Jan 16, 1915 B. R. Reynolds REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from 1913 to 1/14 1914, that I last saw him alive on 4/14 1914, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Permissions Malaria

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

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

(Signed) C. C. Bennett M. D.
9/14 1914 (Address) Bell City 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
<u>Bell city Mo</u>	<u>Sept 15</u> 19 <u>14</u>
UNDERTAKER	ADDRESS
<u>none</u>	

Revised United States Standard Certificate of Death

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

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