

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

PLACE OF DEATH
County Dunklin
Township Union Registration District 282 File No. 31911
or
Village _____ Primary Registration District No. 2491 Registered No. 60
or
City Campbell St.: _____ Ward _____
FULL NAME Harrell W. Cross

[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>Single</u>
DATE OF BIRTH <u>7</u> <u>15</u> <u>1914</u> (Month) (Day) (Year)		AGE <u>2</u> <u>3</u> <u>ds.</u> yrs. mos. ds.
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>		
BIRTHPLACE (City or town, State or foreign country) <u>MO</u>		
PARENTS	NAME OF FATHER <u>Walter Cross</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ark</u>	
	MAIDEN NAME OF MOTHER <u>Cora Miller</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill</u>	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>9</u> <u>18</u> <u>1914</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>9/18</u> , 1914, to <u>9/18</u> , 1914, that I last saw him alive on <u>Mon, 9/18</u> , 1914, and that death occurred, on the date stated above, at <u>5 P.M.</u> , The CAUSE OF DEATH* was as follows: <u>Acute Indigestion</u> <u>had been ill about 1 week</u> (Duration) yrs. mos. ds.	
Contributory (SECONDARY) (Duration) yrs. mos. ds.	
(Signed) <u>G. G. Drummond</u> M. D. <u>1019</u> , 1914 (Address) <u>Campbell Mo</u>	
*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 _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora Miller
(ADDRESS) Was Campbell Mo
Filed 10/10 1914 G. G. Drummond REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Lions Mills</u>	DATE OF BURIAL <u>9-19</u> 191 <u>4</u>
UNDERTAKER <u>none</u>	ADDRESS _____

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*, *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.)

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

PLACE OF DEATH

County Dunklin
Township Union
or
Village
or
City

Registration District No. 282
Primary Registration District No. 5401

File No.
Registered No. 60

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

FULL NAME

Harrell W. Cruse

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF FACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(Write the word)

DATE OF BIRTH Satisfactory (Month) 1 (Day) 1 (Year)

AGE Satisfactory yrs. 1 mos. 0 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 (or employer)

BIRTHPLACE (City or town, State or foreign country)

PARENTS NAME OF FATHER BIRTHPLACE OF FATHER MAIDEN NAME OF MOTHER BIRTHPLACE OF MOTHER

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

Filed 10/10 1914 L. W. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 18 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory to Satisfactory, 1914, that I last saw h alive on, 1914, and that death occurred, on the date stated above at 10:30 m. The CAUSE OF DEATH was as follows: Acute Indigestion

Contributory (Secondary) (Duration) 10 yrs. 0 mos. 0 ds. all one wk.

(Signature) L. W. Brown (Address) Campbell No. 1079 1914

*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, 10 yrs. 0 mos. 0 ds. In the 10 yrs. 0 mos. 0 ds. State Mo.

Where was disease contracted? If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 1914

UNDERTAKER: ADDRESS

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

11612

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