

See leaf.

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

32030

PLACE OF DEATH

County Greene

Township _____

Registration District No. 318

File No. _____

Village _____

Primary Registration District No. 2001

Registered No. 595

City Springfield (NO. Springfield Hospital 2 Ward)

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

FULL NAME Burman J Bearder

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE W. SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH Oct. - 3, 1914
(Month) (Day) (Year)

DATE OF BIRTH Jan. 13, 1851
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 28, 1914, to Oct. 3, 1914,

AGE 63 yrs. ____ mos. ____ ds. IF LESS than 1 day, ____ hrs. or ____ min.?

that I last saw him alive on Oct 3, 1914, and that death occurred, on the date stated above, at 9:20 a.m.

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

The CAUSE OF DEATH* was as follows: Empyema

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

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

PARENTS NAME OF FATHER Elias H. Bearder

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) N. Carolina

(Signed) Lu Cox M. D.
Oct 3, 1914 (Address) 223 Smith

MAIDEN NAME OF MOTHER Nancy Shockley

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

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Flora E. Brooks

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) Springfield Mo

PLACE OF BURIAL OR REMOVAL Maple Park DATE OF BURIAL Oct 4, 1914

Filed Oct 4, 1914 Edwin Johnson REGISTRAR

UNDERSTANDER Edwin Johnson ADDRESS 305 W Walnut

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 of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

County Greene Registration District No. 318 File No. _____
 Township _____ or Village _____ Primary Registration District No. 2001 Registered No. 595
 City Springfield (NO. Springfield Hosp St. 2 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
 FULL NAME Benjamin F. Beasley

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE _____
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) _____

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 Oct 4 1914 Benjamin F. Beasley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 3, 1914
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914, that I last saw him alive on _____, 1914, and that death occurred, on the date stated above, at 930 m.

The CAUSE OF DEATH* was as follows:
Empyema, resulting in absence of lung
 _____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Lee C. Gray M.D.
Oct 3, 1914 (Address) 223 South

*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 _____ 1914

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.
 SUPPLEMENTARY
 Satisfactory Information Supplied.

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

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