

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

PLACE OF DEATH

County: Lincoln

Township _____

or _____

Village _____

or _____

City: Elsberry (NO _____ St.: _____ Ward)

Registration District No. 486

File No. 32734

Primary Registration District No. 4293

Registered No. 28

FULL NAME Ralph R. Robinson

[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

COLOR OR RACE

SINGLE -
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

male

white

DATE OF DEATH

Oct 6, 1914
(Month) (Day) (Year)

DATE OF BIRTH

Feb 4, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 6, 1914, to Oct 6, 1914, that I last saw him alive on Oct 20, 1914, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

AGE

8 yrs. 2 mos. 7 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

9 Pneumonia

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) Elsberry Mo

107A (Duration) yrs. mos. 5 ds.

Contributory Whooping Cough (SECONDARY) (Duration) yrs. mos. ds.

NAME OF FATHER

Claude Robinson

(Signed) A. M. Taylor M. D. Oct 6, 1914 (Address) Elsberry

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Elsberry Mo

MAIDEN NAME OF MOTHER

Mona Pinner

*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) Ohio

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) Claude Robinson

Where was disease contracted If not at place of death?

Former or usual residence _____

(ADDRESS) Elsberry Mo

PLACE OF BURIAL OR REMOVAL Elsberry Mo

DATE OF BURIAL Oct 7, 1914

Filed Oct 8, 1914 C.E. Powell

UNDERTAKER E.S. Morris

ADDRESS Elsberry Mo

REGISTRAR

No. 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 "Asthena," "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 Linn

Township _____

Village _____

City Elberry

Registration District No. 486

File No. _____

Primary Registration District No. 4293

Registered No. 28

St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Ralph R. Robinson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S

DATE OF DEATH _____ 1914
(Month) _____ (Day) _____ (Year) _____

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

I HEREBY CERTIFY, that I attended deceased from _____ 1914 to _____ 1914
that I last saw h _____ alive on _____ 1914

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day _____ hrs. or _____ min.

and that death occurred, on the date stated above, at 6 a 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) _____

Quercyonia Broncho

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

Duration _____ yrs. _____ mos. _____ ds.

NAME OF FATHER _____

Contributory (SECONDARY) Whooping Cough
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) A. M. Taylor M. D.
act 6 1914 (Address) Elberry, Mo.

MAIDEN NAME OF MOTHER _____

*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) _____

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) _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

Filed act 8 1914 C. E. Powell REGISTRAR

UNDERTAKER _____ ADDRESS _____

Supplementary Information Supplied. Satisfactory information supplied. Information supplied.

Supplementary act 6

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGES should be stated EXACTLY.

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

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