

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

1 PLACE OF DEATH

County *Stoddard*

Township *Dexter*

or *Dexter*

Village *Dexter*

or *Dexter*

City (NO *Dexter*)

Registration District No. *838*

File No. *34348*

Primary Registration District No. *4509*

Registered No. *69*

St. *Dexter* Ward

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

2 FULL NAME *Ben Wesley Oliver*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4. COLOR OR RACE *White* 5 SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH *June 15 1862*
(Month) (Day) (Year)

7 AGE *6-2 yrs. 4 mos. 12 ds.* If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Machinist*
(b) General nature of industry business, or establishment in which employed (or employer) *Running mill*

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

10 NAME OF FATHER *John Covell*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *South Carolina*

12 MAIDEN NAME OF MOTHER *Cloys*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Virginia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Chas. Oliver*

(Address) *Dexter Mo*

15 Filed *Oct 30 1914* *Chas. Walker*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 27 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Oct 5 1914* to *Oct 27 1914* that I last saw him alive on *Oct 27 1914* and that death occurred, on the date stated above, at *5 P m.*

The CAUSE OF DEATH* was as follows:
Myocarditis
937
1864

(Duration) *10* yrs. *10* mos. *10* ds.

CONTRIBUTORY *Fracture of leg (open)*
(Secondary)

(Duration) *7* yrs. *2* mos. *2* ds.

(Signed) *Wm. C. Dickman* M. D.

Oct 28 1914 (Address) *Dexter Mo*

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *7* yrs. *2* mos. *2* ds. In the State *7* yrs. *2* mos. *2* ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Dexter County* DATE OF BURIAL *Oct 29 1914*

20 UNDERTAKER *D. Begg* ADDRESS *Dexter 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, 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.)

N. B.—Every item of information should be carefully supplied. AGE could be used EXACTLY. PHYSICAL STATEMENT OF OCCUPATION a very important CAUSE OF DEATH in plain terms, so that it may be properly classified.

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

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

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

Registration District No. 838 File No. _____
 Primary Registration District No. 4509 Registered No. 69

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

FULL NAME Bru Wesley Alvers

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> <small>(Write the word)</small>	DATE OF DEATH <u>Oct 27</u> , 191 <u>4</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH _____, 191____, to _____, 191____ <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at <u>5 P</u> M.	
AGE ____ yrs. ____ mos. ____ ds.		If LESS than 1 day, ____ hrs. or ____ min.	The CAUSE OF DEATH* was as follows: <u>Myocardial acute</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			CONTRIBUTORY (SECONDARY) <u>Fracture of Hip (Open)</u> (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>W C Dickerson</u> M. D. <u>Oct 28</u> 191 <u>4</u> (Address) <u>Dexter</u>	
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 _____			*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? _____	
(ADDRESS) _____			Former or usual residence _____	
Filed <u>Oct 30</u> 191 <u>4</u> <u>Alphas E. Mallett</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____	
			UNDERTAKER _____ ADDRESS _____	

SUPPLEMENTARY CERTIFICATE

Original file, date _____ 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

34348

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) *Colton 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.)

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

Registration District No. 838 File No. 34348
Primary Registration District No. 4509 Registered No. 69

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

FULL NAME Bru Wesley Oliver

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>
DATE OF BIRTH (Month) _____ (Day) _____ (Year) _____		
AGE _____ mos. _____ 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 (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

DATE OF DEATH Oct 27, 1914
(Month) _____ (Day) _____ (Year) _____

HEREBY CERTIFY, that I attended deceased from _____, 191____, that I saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 5P m.

THE CAUSE OF DEATH* was, as follows:
Myocarditis Acute
Accidental fall from scaffold
(Duration) _____ yrs _____ mos _____ ds.

Contributory fracture of leg (open)
(SECONDARY) (Duration) _____ yrs _____ mos _____ ds.

(Signed) Wm C Dickman M. D.
Oct 28 1914 (Address) Dexter Mo

SUPPLEMENTARY

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____
Filed Oct 30 1914 Paul Walker 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 _____ 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____
ADDRESS _____

UNDERTAKER _____

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