

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

PLACE OF DEATH

County Linn

Township _____

or _____

Village _____

or _____

City Brookfield

Registration District No. 496

File No. 39375

Primary Registration District No. 3025

Registered No. 74

(NO. 207 So Livingston St. Ward 8)

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

FULL NAME Harry Wilson McBlason

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec 4 1885
(Month) (Day) (Year)

AGE 29 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS NAME OF FATHER Thomas McBlason BIRTHPLACE OF FATHER Kentucky
MAIDEN NAME OF MOTHER Susan P. Ryan BIRTHPLACE OF MOTHER Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. H. W. McBlason
(ADDRESS) Brookfield Mo.

Filed 12/13 1914 L. Howard REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 11 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage (Homicidal)

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

Contributory Fractured skull (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. O. Howe (Coroner) M. D. Dec. 11 1914 (Address) Linn 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 Shubina, Mo. DATE OF BURIAL 12-13-1914

UNDERTAKER R. N. Bowden, Brookfield Mo. 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

Franklin

Township

Registration District No.

496

File No.

or

Village

Primary Registration District No.

Registered No.

71

or

City

Brookfield (NO. *207* *Belvington* St. *4* Ward)

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

FULL NAME

Harry Wilson McGlasson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

M

W

M

DATE OF DEATH

Dec 11, 191*4*
(Month) (Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied
(Month) (Day) (Year)

AGE

If LESS than
1 day, hrs. or min.
yrs. mos. ds.

I HEREBY CERTIFY, that I attended deceased from
Satisfactory Information Supplied, 191*4*,
that I last saw h*is* alive on _____, 191*4*,
and that death occurred, on the date stated above, at _____ m.

OCCUPATION,
(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage
(Homicidal)
Blow on head with blunt instrument*
(Duration) yrs. mos. ds.

BIRTHPLACE

(City or town,
State or foreign country)

Contributory *Fracture of Skull*
(SECONDARY)
(Duration) yrs. mos. ds.

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)

(Signed) *L.O. Hoque* (Crown) M. D.
Dec 11, 191*4* (Address) *Summers 710*

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

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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)

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Filed

12/13 191*4*
1/29/15 *H. Howard*
REGISTRAR

Satisfactory Information Supplied

N. B. - If item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE
 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]

39875

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