

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

PLACE OF DEATH

*New Madrid*

Ship *Anderson*

Registration District No. *55*

File No. *39597*

Age *4*

Primary Registration District No. *4033*

Registered No. *14*

*Gideon* (NO. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME *Charles Wesley McDowell*

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH *Nov 25 1868*  
(Month) (Day) (Year)

AGE *46* yrs. *15* mos. *15* ds. IF LESS than 1 day; \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) *Do not know*

NAME OF FATHER *Geo McDowell*

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

MAIDEN NAME OF MOTHER *Do not know*

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant *Nellie McDowell*  
(ADDRESS) *Gideon Mo*

Filed *Dec 28 1914* M. V. Munn  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Nov 20 1914*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov 20 1914*, to *Nov 20 1914*, that I last saw him *alive* on *Nov 20 1914*, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
*By Gunshot*  
*Wound*  
*173*  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) *Edward W. Cottrell* M. D.  
*Nov 20 1914* (Address) *Gideon 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 *St. Bernard* DATE OF BURIAL *Nov 22 1914*  
UNDERTAKER *A. C. Smith* ADDRESS *Gideon Mo*

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St.: \_\_\_\_\_

Ward \_\_\_\_\_

If death occurred  
in hospital or last  
give its NAME  
of street and number.

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	_____, _____, 19____	(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs., \_\_\_\_\_ 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) \_\_\_\_\_

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 \_\_\_\_\_, 19\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

\_\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_ that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_ and that death occurred, on the date stated above, at \_\_\_\_\_ M. The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

## Contributory

(SECONDARY)

(Signed) \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

\*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, RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the Where was disease contracted if not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

## PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## UNDERTAKER

## ADDRESS

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

*New Madrid*

Town or Village

City

Street

Ward

Registration District No.

*55*

File No.

Primary Registration District No.

*4033*

Registered No.

FULL NAME

*Chas. Lesley Mc Dowel*

(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 *M* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED *M* (If write the word)

DATE OF DEATH

*Nov 20*, 191*4*  
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from *factory information supplied*, 191*4*, to *factory information supplied*, 191*4*, that I last saw him alive on *factory information supplied*, 191*4*.

AGE (yrs. mos. ds.) IF LESS than 1 day, hrs. or min.

and that death occurred, on the date stated above, at *factory information supplied* 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:

*By gun shot wound*  
*Homicidal* / *187*  
(Duration) yrs. mos. ds.

PLACE (a) town, or foreign country

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

NAME OF FATHER

(Signed) *Thos. Collier* M.D.  
*11/20*, 191*4* (Address) *Lidon Mo*

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)

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Signature)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Address)

Where was disease contracted If not at place of death?

(Address)

Former or usual residence

(Address)

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191*4*

REGISTRAR

UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY

# 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

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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.)