

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

5015

~~4857~~

PLACE OF DEATH

County Jackson  
Township Prarie  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 400 File No. \_\_\_\_\_  
Primary Registration District No. 5553B Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

FULL NAME

Thomas Gilmerston

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed  
(If write the word)

DATE OF BIRTH Feb 25, 1825  
(Month) (Day) (Year)

AGE 89 yrs. 9 mos. 6 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

PARENTS  
NAME OF FATHER Edward Gilmerston  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland  
MAIDEN NAME OF MOTHER Margaret Whalen  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Johnny George  
(ADDRESS) Little Blue Mo.

Filed 2-1-1915 W. M. Hutchins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2-1-1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 29, 1915, to Feb 1, 1915, that I last saw him alive on Jan 31, 1915, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia  
100  
75B  
(Duration) \_\_\_ yrs. \_\_\_ mos. 4 ds.

Contributory Intemperance  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) Johnny George M. D.  
2-1-1915 (Address) Little Blue 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 2 yrs. 1 mos. 19 ds. In the 35 yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence Kansas City Mo.

PLACE OF BURIAL OR REMOVAL County, Mo. DATE OF BURIAL 2-1-1915  
UNDERTAKER W. M. Hutchins ADDRESS Little Blue Mo.

CAUSE OF DEATH in plain language. Exact statement of OCCUPATION in plain language.

# 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, peritonacum*, etc., *Carcinoma, Sar-*

*coma*, 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.)



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

should be carefully supplied, AGE should be properly classified, EXACTLY, as persons should state very in

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

Registration District No. 400 File No. \_\_\_\_\_  
Primary Registration District No. 5553B Registered No. 7  
(NO. St. Ward)

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

FULL NAME Thomas Glevartin

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH (Month) _____ (Day) <u>1</u> (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) _____		

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH _____ 19 <u>15</u> (Month) _____ (Day) _____ (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 19 <u>15</u> , to _____, 19 <u>15</u> , that I last saw h. _____ alive on _____, 19 <u>15</u> , and that death occurred, on the date stated above, at <u>3:30 a.m.</u>
The CAUSE OF DEATH* was as follows: <u>Obat Pneumonia</u>
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) <u>Henry George Little</u> M. D. 19 <u>15</u> (Address) _____
*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. 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 _____ 19 <u>15</u>
UNDERTAKER _____
ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
Filed 7/1 1915 S. A. W. Haman REGISTRAR

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