

PLACE OF DEATH

County WarrenTownship BridgeportVillage WarrenCity Warren (NO. Warren St. Warren Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 881File No. 7202Primary Registration District No. 6172Registered No. 9FULL NAME Charles Claborn

[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 Colored SINGLE MARRIED Married
WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH June 2, 1821
(Month) (Day) (Year)AGE 93 yrs. 8 mos. 12 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) Potosi, Indian TerritoryPARENTS
NAME OF FATHER Not known
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER Not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Champ
(ADDRESS) McKittick, Mo.Filed Feb 16 1915 W. B. Morse
By Anton Karl REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 14, 1915
(Month) (Day) (Year)I HEREBY CERTIFY that I attended deceased from 2-12, 1915, to 2-12, 1915,
that I last saw him alive on 2-12, 1915,
and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

100
Neuronia
(Duration) ___ yrs. ___ mos. 5 ds.Contributory (SECONDARY)
8 (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. L. Leslie M. D.
2-11 1915 (Address) McKittick

*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 McKittick Cemetery DATE OF BURIAL Feb 17, 1915UNDERTAKER Anton Karl ADDRESS Case, 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*, *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) *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 "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 septichaemia," "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 Narvon
 Township Bridgeport
 or
 Village
 or
 City (NO. _____) _____

Registration District No. 881
 Primary Registration District No. 6172

File No. _____
 Registered _____

FULL NAME Charles Claborn

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE

SEX M COLOR OF RACE B. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M.

DATE OF DEATH 2-16-1915
 (Month) (Day) (Year)

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

HEREBY CERTIFY, that I attended deceased from _____
 that I last saw him _____

AGE _____
 If LESS than 1 day, _____ hrs. or _____ min.

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

Lobar Pneumonia

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

Contributory (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) J. H. Resler M.D.
 2-16-1915 (Address) McKittick
 *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 and disease contracted _____
 If _____
 If _____
 If _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

(ADDRESS) _____
 Filed Mar 31 1915 _____
 REGISTRAR _____

DATE OF BURIAL _____ 191____
 Satisfactory Information Supplied.

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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