

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

1 PLACE OF DEATH

County Marion

9331

Township _____

Registration District No. 547

File No. _____

Village _____

Primary Registration District No. 2079

Registered No. 69

City Hannibal (No. 14089 Market, 5 St. 5 Ward)

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

2 FULL NAME Charles O. Scothorn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the status) Single

6 DATE OF BIRTH Sept 2 1842
(Month) (Day) (Year)

7 AGE 72 yrs. 6 mos. 25 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Ohio

10 NAME OF FATHER Benjamin T. Scothorn

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio

12 MAIDEN NAME OF MOTHER Evelyn Ogle

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Joe H. Scothorn
(Address) Hannibal

15 Filed March 29 1915 Registrar W. H. Jones

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 27 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 24, 1915, to March 27, 1915, that I last saw him alive on March 27, 1915, and that death occurred, on the date stated above, at 10:00 p.m.

The CAUSE OF DEATH* was as follows:

La Grippe
IIA
106A From history about
(Duration) 7 mos. 14 ds.
CONTRIBUTORY Bronchitis
(Secondary) (Duration) 6 yrs. 7 mos. 27 ds.

(Signed) Mrs. Channing M. D.
1915 (Address) _____

*State the Disease Causing Death, or, in deaths 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. 6 mos. 27 ds. In the State 7 yrs. 6 mos. 27 ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Crossside Cemetery DATE OF BURIAL Mar 29, 1915

20 UNDERTAKER Severs & Co. Hannibal ADDRESS _____

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; a void

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 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.

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Marion
Township _____
or
Village Annibal
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 547 File No. _____
Primary Registration District No. 3029 Registered No. 69

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

FULL NAME Charles O. Scothorn

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W.</u>	SINGLE <u>S.</u> MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, 191____, to _____, 191____, (Month) (Day) (Year)		AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ 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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/27/15
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him _____, 191____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Pneumonia

Contributory Acute Bronchitis
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thos Chauricey M.D.
3/27/15 (Address) Annibal 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. _____ 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____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) _____
(ADDRESS) _____
Filed Mar 29 1915 N. V. Jones
REGISTRAR

Revised United States Standard Certificate of Death

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

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1386
933

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