

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

PLACE OF DEATH
County Caldwell
Township _____
or
Village _____
or
City Hamilton (NO. _____) St. 2nd Ward

Registration District No. 96 File No. 11776
Primary Registration District No. 4058 Registered No. 16

FULL NAME Charles Oliver Mitchell

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 1871
(Month) (Day) (Year)

AGE 44 yrs. 9 mos. 9 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 34 23 A

BIRTHPLACE (City or town, State or foreign country) Davis Co. Mo. 84 D

NAME OF FATHER Strather M. Mitchell

BIRTHPLACE OF FATHER (City or town, State or foreign country) Davis Co. Mo.

MAIDEN NAME OF MOTHER Rebecca Lindsey Terrell

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Howard Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. P. C. Galt
(ADDRESS) Hamilton Mo.

Filed April 5 1915 Timothy Mours REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Ap 13th 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1913, to Ap 1915, that I last saw him alive on Oct 10th 1915, and that death occurred, on the date stated above, at 6 A.m.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) one yrs. ___ mos. ___ ds.
Contributory T.B. and Syphilis
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Neill S. Johnson M. D.
4/13 1915 (Address) Hamilton 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 Highland Cemetery DATE OF BURIAL Apr 10, 1915

UNDERTAKER John Houghton ADDRESS Hamilton Mo.

N. B.—Every item of information should be carefully supplied. 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 *septicæmia*," "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.)

PLACE OF DEATH

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

County Caldwell

Township _____

Village _____

City Hamilton (NO. _____)

Registration District No. 96

Primary Registration District No. 4058

File No. _____

Registered No. 16

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

FULL NAME Charles Oliver Mitchell

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OF RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Widower

DATE OF BIRTH _____ (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) _____

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 _____ 1915 Henry Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 13, 1915 (Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw h _____ alive on _____, 1915,

and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Paralysis
Left side Hemiplegia with
Pulmonary Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds. Contributory T.B. & Syphilis (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Keill Johnson M.D. 4/13, 1915 (Address) Hamilton 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 _____ DATE OF BURIAL _____ 1915

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

AGE 18-24 25-34 35-44 45-54 55-64 65-74 75-84 85-94 95-104

Revised United States Standard Certificate of Death

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

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