

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

PLACE OF DEATH

County Douglas  
Township Spring creek  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 1974  
Primary Registration District No. 5382

File No. 12142  
Registered No. \_\_\_\_\_

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

FULL NAME

Robert Francis Brown

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE <u>Single</u> MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec</u> <u>1</u> , 19 <u>15</u> (Month) (Day) (Year)		
AGE <u>3</u> <u>27</u> yrs. mos. ds.		IF LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH  
March 27, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 21, 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 7 a.m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia complicated with cerebrospinal meningitis  
7913 (Duration) yrs. mos. ds. 6

Contributory (SECONDARY)  
107 A (Duration) yrs. mos. ds. 1  
(Signed) Win Daniels M. D.  
March 28, 1915 (Address) Ava 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 3 27 In the 3 27  
yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted  
If not at place of death?  
Former or usual residence none

PLACE OF BURIAL OR REMOVAL <u>Beland Graves</u>	DATE OF BURIAL <u>March 28, 1915</u>
UNDERTAKER <u>Neighbors</u>	ADDRESS <u>Squires Pk</u>

OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE  
(City or town, State or foreign country) Douglas Co Mo

PARENTS	NAME OF FATHER <u>James Brown</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Douglas Co Mo</u>
	MAIDEN NAME OF MOTHER <u>Nancy E Thomas</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dent Co Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) James Brown  
(ADDRESS) 2 Squires

Filed April 10, 1915, D J Bailey  
REGISTRAR

## 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");  $\frac{1}{2}$  *Diphtheria* (avoid use of "Croup");  $\frac{1}{2}$  *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, 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 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.)

PLACE OF DEATH

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

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County

Township

Village

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

No.

St.

Ward)

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

FULL NAME

Robert Francis Brown

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

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

April 10 1915 J. P. Bailey

REGISTRAR

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was, as follows:

Pneumonia complicated with cerebro spinal meningitis  
Bronchial pneumoniaContributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) William Daniels  
3/28 1915 (Address) Ava 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

UNDERTAKER

ADDRESS

Original file, date

April - 1915

All information called for must be written on this Supplementary Certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is important. If in plain terms, so that it may be properly classified. Satisfactory Information Supplied.

Satisfactory Information Supplied. SUPPLEMENTARY

Satisfactory Information Supplied. I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was, as follows: Pneumonia complicated with cerebro spinal meningitis Bronchial pneumonia Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) William Daniels 3/28 1915 (Address) Ava 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 UNDERTAKER ADDRESS

# Revised United States Standard Certificate of Death

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

2121

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