

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

1 PLACE OF DEATH

County Ozark
Township Bayan
or
Village
or
City

Registration District No. 647

File No. 7

13574

Primary Registration District No. 887

Registered No. 7

(NO. St. Ward)

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

2 FULL NAME

Ray Everett Butcher

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH April 29th 1915
(Month) (Day) (Year)

6 DATE OF BIRTH June 17 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 11, 1915 to April 16th, 1915 that I last saw h. 16 alive on April 16, 1915

7 AGE 10 yrs. 6 mos. 6 ds. IF LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

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

Erysipelas

9 BIRTHPLACE (City or town, State or foreign country) Ozark County Mo

(Duration) yrs. mos. 17 ds.

10 NAME OF FATHER James Butcher

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

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

(Signed) Chas. J. Greene M. D.

12 MAIDEN NAME OF MOTHER Rachel Mitchell

(Address) Bakersfield Mo

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ozark Co Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant) Rachel Butcher
(Address) Bakersfield Mo

At place of death yrs. mos. ds. In the State yrs. mos. ds.

15 Filed April 30, 1915 L. W. Gannon Registrar

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hammans Ridge Mo DATE OF BURIAL April 24 1915

20 UNDERTAKER Bob Bray ADDRESS Bakersfield Mo

AGE should be stated EXACTLY. PHYSICIAN should state by 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 included: *Farmer (retired, 8 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 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.)

B.—Every item of information should be carefully supplied, and the person furnishing the same should be stated EXACTLY as it appears on the original record. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Clark
 Township Bayon
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 647 File No. _____
 Primary Registration District No. 5857 Registered No. 7

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

FULL NAME Ray Everett Butcher

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W
 SINGLE MARRIED WIDOWED OR DIVORCED
 (Write the word)

DATE OF BIRTH _____, 191____
 (Month) (Day) (Year)

AGE _____ 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) _____

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) _____

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

Filed 4/30 1915 L. W. Lawrence
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 23, 1915
 (Month) (Day) (Year)

Satisfactory information 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 5 P. m.

The CAUSE OF DEATH* was as follows:
Empyema
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Oedema of the
glottis (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Chas. F. Greene M. D.
4/29 1915 (Address) Bakerfield 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 hrs 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 _____, 191____

UNDERTAKER _____ ADDRESS _____

APR - 1915

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

Revised United States Standard Certificate of Death

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

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