

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 14977

PLACE OF DEATH

County Scotts

Township _____

or

Village _____

or

City Memphis Mo (NO. _____)

Registration District No. 810

File No. 21

Primary Registration District No. 4488

Registered No. 21

St.: _____ Ward)

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

FULL NAME Parley Howlett Bennett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(If ritis the word)

DATE OF DEATH 4-14, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-1, 1915, to 4-14, 1915, that I last saw him alive on 4-14, 1915, and that death occurred, on the date stated above, at 7-43^P A.M.

AGE 21 yrs. 3 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

Heart trouble

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

(Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Jno G. Bennett

Contributory Pneumonia
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) W E Gogh D O M. D.

MAIDEN NAME OF MOTHER Melissa Boone

4-14, 1915 (Address) Memphis Mo

BIRTHPLACE OF MOTHER (City or town, State or foreign country) New Jersey

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs P H Bennett

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

Former or usual residence _____

(ADDRESS) Memphis Mo

PLACE OF BURIAL OR REMOVAL Madison Cemetery DATE OF BURIAL 6 full 17, 1915

Filed 4/15, 1915 REGISTRAR D W Payne

UNBERTAMER ADDRESS _____

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*, *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 "Asthemia," "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*, *telanus*) 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.

County Scotland

Township _____ Registration District No. 810 File No. _____

or Village _____ Primary Registration District No. 4488 Registered No. 21

or City Murphys (NO. _____) St. _____ Ward _____

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

FULL NAME Parley Howlett Bennett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1915,
that I last saw him alive on _____, 1915.

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

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

Heart trouble
Natural

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

(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER _____

Contributory Bronch Pneumonia
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) W E Fogle D.D.
1915 (Address) Murphys

MAIDEN NAME OF MOTHER _____

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915

Filed 4/16 1915 W E Fogle REGISTRAR

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.

SUPPLEMENTARY

