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

**PLACE OF DEATH**

County: Cape Guardeau

Township: Shoemaker

or Village: ~~Neelys Ldg Mo~~

or City: _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 129 — File No. 15503

Primary Registration District No. 5780 — Registered No. 13

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

**FULL NAME** James M Robinson

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | white | Single |

DATE OF BIRTH: Dec (Month) 23 (Day), 1897 (Year)

AGE: 18 yrs. 5 mos. 5 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Jackson Mo

PARENTS
- NAME OF FATHER: James Robinson
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Oak Ridge Mo
- MAIDEN NAME OF MOTHER: Mary E Hartel
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Smithville Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Robinson

(ADDRESS) Neelys Ldg Mo

Filed May 28 1915 R D V Taylor REGISTRAR

**MEDICAL CERTIFICATE OF DEATH** 2

DATE OF DEATH: May (Month) 28 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from May 22, 1915, to May 28, 1915, that I last saw him alive on May 28, 1915, and that death occurred, on the date stated above, at 2 Am.

The CAUSE OF DEATH* was as follows:

Peritonitis
120 B
129

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

Contributory (SECONDARY) _____

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

(Signed) Oliver J Miller M. D.

May 28 1915 (Address) Neelys Ldg 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: Neelys Ldg

DATE OF BURIAL: May 29 1915

UNDERTAKER: Robt P Ruff

ADDRESS: Pocahontas Mo

...information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...ATH 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 *septichaemia*," "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
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**1 PLACE OF DEATH**

County Cape Gnd

Township Shawnee

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 129 File No.

Primary Registration District No. 5780 Registered No. 13

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

2 FULL NAME James M. Robison

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX M

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH Dec (Month) 23 (Day) 1897 (Year)

7 AGE 18 yrs. 5 mos. 15 ds. If LESS than 1 day, ....hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER James Robison

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Oak Ridge Mo

12 MAIDEN NAME OF MOTHER Mary E Hartle

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Robison

(Address) Neelys Landing

Filed May 28 1915 R D Blaylock Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH May (Month) 28 (Day) 1915 (Year)

17 I HEREBY CERTIFY that I attended deceased from ....., 191.... to ....., 191.... that I last saw alive on ....., 191.... and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis

the immediate again attack of Enterocolitis

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

CONTRIBUTORY (Secondary)

Peritonitis (Duration) ....yrs. ....mos. 24 hrs ds.

(Signed) Oliver J Miller M. D.

May 28 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 ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Indian Creek Cem

DATE OF BURIAL May 29 1915

20 UNDERTAKER Robt Ruff

ADDRESS Pocahontas Mo

Original file, date 28 1915 19....

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

SUPPLEMENTARY

Satisfactory Information Supplied.

14-0 - 5-0
53-2 36-4

# Revised United States Standard Certificate of Death

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

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