

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.

PLACE OF DEATH

County Shannon
 Township Spring Creek
 or
 Village _____
 or
 City _____

Registration District No. 526

Primary Registration District No. 6044

CERTIFICATE OF DEATH

File No. 418016

Registered No. 4

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

FULL NAME J. R. Bradley

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ Married
 (Write the word)

DATE OF BIRTH

July 6, 1854
 (Month) (Day) (Year)

AGE

60 yrs. 6 mos. 7 ds. If LESS than 1 day, — hrs. or — min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Laborer Lead mines Lumber

(b) General nature of industry, business, or establishment in which employed (or employer) 23A

BIRTHPLACE

(City or town, State or foreign country) Phelps Co., Mo.

PARENTS

NAME OF FATHER

Jos H. Bradley

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Tenn.

MAIDEN NAME OF MOTHER

Malinda McCloud

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Bradley

(ADDRESS) Not Mo.

Filed 5-20 1915 E. C. Butcher

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July 13, 1915
 (Month) (Day) (Year)

I 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:

Tuberculosis of Lungs

Contributory (SECONDARY)

(Signed)

None M. D. 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.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. 5 mos. — ds. In the State 8 yrs. — mos. — ds.

Where was disease contracted if not at place of death? Webb City Mo.

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Corinth Cemetery

UNDERTAKER

none

DATE OF BURIAL

Jan 14, 1915

ADDRESS

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 "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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A SUPPLEMENTARY RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated IN FULL. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County Shannon
 Township Spring Creek
 or
 Village
 or
 City

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

Registration District No. 825 File No. 4
 Primary Registration District No. 6044 Registered No.
 (NO. St. Ward)

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

2 FULL NAME

Bindley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> (Write the word)
6 DATE OF BIRTH (Month) (Day) (Year) 1. 2. 3.		
7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	12 MAIDEN NAME OF MOTHER	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)

15 Filed 5/20 1915 Orin Butcher
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan 13 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
 191 to 191
 that I last saw him alive on 191
 and that death occurred, on the date stated above, at m.
 The CAUSE OF DEATH* was as follows:
Tuberculosis Lungs
 (Duration) yrs. mos. ds.
 CONTRIBUTORY
 (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) X E. C. Bradley
8-31, 1915 (Address) Not, mo

*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 disease contracted if not at place of death?
 Former or usual residence.

19 PLACE OF BURIAL OR REPOSING
 DATE OF BURIAL

20 UNDERTAKER
 ADDRESS

Original file, date May 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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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), 29ds.; *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.)