

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

18572

PLACE OF DEATH

County Clinton  
Township Clinton  
or  
Village Gowen  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 205  
Primary Registration District No. 4123

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

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

FULL NAME Robert L Moore

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>January 31, 1883</u> (Month) (Day) (Year)		
AGE <u>32 yrs 4 mos 3 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Clinton Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>John W. Moon</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	MAIDEN NAME OF MOTHER <u>Frances W. McClellan</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 6 / 3, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1st, 1915, to 6/3, 1915, that I last saw him alive on 6/3, 1915, and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH\* was as follows:  
Tuberculosis of the lungs  
20 H  
1915 (Duration) X yrs. 8 mos. X ds.

Contributory Injury to head  
(SECONDARY) (Duration) X yrs. 10 mos. X ds.  
(Signed) B. W. Tadlock M. D.  
6/3, 1915 (Address) Gowen 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) M. H. Moore  
(ADDRESS) Earborn Mo

PLACE OF BURIAL OR REMOVAL Allen Daleburn DATE OF BURIAL June 5, 1915  
UNDERTAKER Hollins & Davis ADDRESS Edgerton Mo

Filed 6/8, 1915 B. W. Tadlock REGISTRAR

N. B.—Every item of information should be given. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it can be readily 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, 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.)

## 1 PLACE OF DEATH

County

Township  
orVillage  
or

City

## 2 FULL NAME

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

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

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.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>M</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>Satisfactory Information Supplied.</i>		
7 AGE <i>Satisfactory Information Supplied.</i>		If LESS than day.....hrs. .....yrs.....mos.....ds. .....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)

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

1915

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

191

(Year)

17 I HEREBY CERTIFY, that I attended deceased from  
191....., 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 of the lungs. Blow on head with pitchfork*  
*accidental injury to head*  
CONTRIBUTORY (Secondary)  
*injury to head*  
(Signed) *B. W. Tadlock*  
1915 (Address) *Gower 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..... 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

DATE OF BURIAL

191

BY UNDERTAKER

ADDRESS

Original file, date JUN - 1915, 19.....

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

Satisfactory Information Supplied.

SUPPLEMENTARY

Satisfactory Information Supplied.

PHYSICIANS should state  
OCCUPATION is very important.

refully certified.  
if may be possible.  
N. B. - Every item of info.  
CAUSE OF DEATH

FILED

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*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 inter-current) 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.)

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