

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

PLACE OF DEATH
County Pettis ✓
Township Washington Registration District No. 664 File No. 22540
or
Village _____ Primary Registration District No. 5884 Registered No. 87
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Robert Thomas Whitaker

PERSONAL AND STATISTICAL PARTICULARS

N MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH June 28, 1915
(Month) (Day) (Year)

DATE OF BIRTH Feb 14, 1842
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1913, to March 28, 1915, that I last saw him live on March 27, 1915, and that death occurred, on the date stated above, at 6 P m.

AGE 73 yrs. 4 mos. 24 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 Farmer 188
(b) General nature of industry, business, or establishment in which employed (or employer) Industry 116

General debility
fractured his Hip 3-12
1913-

BIRTHPLACE (City or town, State or foreign country) Scholar Mo

(Duration) 24 yrs. 9 mos. 9 ds.

NAME OF FATHER Newton Whitaker

Contributory Accident
(SECONDARY)

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

(Duration) 2 yrs. 3 mos. 0 ds.

MAIDEN NAME OF MOTHER Maria Thomas

(Signed) T. W. Olobaugh M. D.
7-10 1915 (Address) OW Olobaugh

BIRTHPLACE OF MOTHER (City or town, State or foreign country) N.Y.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE-

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

(Informant) Mrs T R Brown
(ADDRESS) Greensburg Mo

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 _____

Filed 7-10 1915 OW Olobaugh
REGISTRAR

PLACE OF BURIAL OR REMOVAL Greensburg Mo DATE OF BURIAL July 17 1915

UNDERTAKER W B Brown & Son's ADDRESS Greensburg Mo

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 "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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH

County Pettis
 Township Washington
 or
 Village
 or
 City

Registration District No. 664 File No.
 Primary Registration District No. 5884 Registered No. 87
 St. Ward

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

2 FULL NAME Robert Thomas Whitaker

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
 (Month) (Day) (Year)

7 AGE
 If LESS than 1 day... hrs. or... min.?
 mos. ds.

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 7/10 1915 OW Clabaugh
 Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from the date of death to the date of burial, and that death occurred, on the date stated above, at... m.

THE CAUSE OF DEATH* was as follows:
Chronic disability
Fractured hip 3-12
Cause 1 risk by Horse
Accident
 (Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cause
 (Signed) OW Clabaugh M. D.
7/10 1915 (Address) Not subscribed

*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 DATE OF BURIAL 1915

20 UNDERTAKER ADDRESS

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Satisfactory Information Supplied.
 SUPPLEMENTARY INFORMATION SUPPLIED.
 Satisfactory Information Supplied.

Original file, date JUL -- 11 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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