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

PLACE OF DEATH

County Pettis

Township ______ or Village ______ or City Sedalia (No. ______ St., ______ Ward)

Registration District No. 668 — File No. 22547

Primary Registration District No. 3032 — Registered No. 180

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

FULL NAME Thomas Abanathy

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: Black

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): ——

DATE OF BIRTH: ______ (Month) ______ (Day), ______ (Year)

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

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

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

PARENTS:
NAME OF FATHER ______
BIRTHPLACE OF FATHER (City or town, State or foreign country) ______
MAIDEN NAME OF MOTHER ______
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______

Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) None

(ADDRESS) ______

Filed July 7, 1915 — W. B. Ross, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 4 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from 6-29, 1915, to 7-4, 1915, that I last saw him alive on 7-4, 1915, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:
Fract Skull and injury to brain 144B (Accidental)
(Duration) ______ yrs. ______ mos. 7 ds.

Contributory (Secondary) ______
(Duration) ______ yrs. ______ mos. ______ ds.

(Signed) M R Sly, M. D.
7-4, 1915 (Address) Sedalia

*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: Crown Hill — DATE OF BURIAL: July 7, 1915

UNDERTAKER: McLaughlin Bros — ADDRESS: Sedalia, Mo.

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

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

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

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

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:

_____

_____

_____

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

Contributory_____
(SECONDARY)

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

(Signed)_____ M. D.

_____, 191____ (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. ____ 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	DATE OF BURIAL _____, 191____
UNDERTAKER	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.

In Qry.

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

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

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.

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

1 PLACE OF DEATH

County Pettis

Township or Village or City Sedalia (NO. ...... St. ...... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registration District No. 668

Primary Registration District No. 3032

File No. ......

Registered No. 180

2 FULL NAME Thomas Abanathy

SUPPLEMENTARY

Satisfactory Information Supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE B

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) unk —

6 DATE OF BIRTH ...... (Month) ...... (Day), 1...... (Year)

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 July 7 1915 W. B. Reed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4 (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ......, 191...., to ......, 191....,

that I last saw h...... alive on ......, 191....,

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

The CAUSE OF DEATH* was as follows:

Fracture skull and injury to brain

cause not known accidental

he was found in this condition

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

CONTRIBUTORY (Secondary) ......

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

(Signed) M. R. Sup[illegible] M. D.

7/4, 1915 (Address) Sedalia 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 was disease contracted if not at place of death? ......

Former or usual residence ......

19 PLACE OF BURIAL OR REMOVAL ......

DATE OF BURIAL ......, 191....

20 UNDERTAKER ......

ADDRESS ......

JUL -- 1915

Original file, date ......, 19......

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]

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), *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 *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.)