

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

PLACE OF DEATH

County Pulaski
Township Roubidoux
or XXXXXXXX
Village XXXXXXXXXX
or XXXXXXXXXXXXXXXXXXXX
City XXXXXXXXXXXXXXXXXXXX (NO. _____ St.: _____ Ward _____)

Registration District No. 710
Primary Registration District No. 5944

File No. 22636
Registered No. _____

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

FULL NAME XXXXXXXXXXXXXXXXXXXX

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male.</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>July 26, 1915</u> (Month) (Day) (Year)		
AGE <u>X</u> yrs. <u>X</u> mos. <u>X</u> ds.		IF LESS than 1 day, _____ hrs. or 30 min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Pulaski Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Jake Starnes.</u>	
	BIRTHPLACE OF FATHER <u>Missouri</u> (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER <u>Belle Logan.</u>	
	BIRTHPLACE OF MOTHER <u>Missouri.</u> (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 26, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 26, 1915, to July 27, 1915, that I last saw him alive on July 26, 1915, and that death occurred, on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:
By Mother falling from wagon causing Premature Birth.

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Douglas Wyatt M. D.
July 27, 1915 (Address) Cookville, 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 DATE OF BURIAL _____, 1915

UNDERTAKER _____ ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jake Starnes
(ADDRESS) Roubidoux Mo
Filed 7 30, 1915 - RCY Jowett
REGISTRAR

This form should be filled out by the physician or other person who has attended the deceased. Exact statement of OCCUPATION is very important. It should be properly classified, so that it may be properly classified.

PLACE OF DEATH

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 _____ (Month) _____, 19____ (Day) _____, 19____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds. _____

IF LESS than
1 day, _____ hrs. _____ min.?
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) _____

NAME OF FATHER
(City or town, State or foreign country) _____

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

MAIDEN NAME OF MOTHER
(City or town, State or foreign country) _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 19____, _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 19____ (Day) _____, 19____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

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) _____ (Address) _____, 19____ (M. D. _____)

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____, 19____

DATE OF BURIAL _____, 19____

UNDERTAKER _____

ADDRESS _____

This is a permanent record

Age should be stated exactly. Physician should state occupation, if important.

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 Pulaski
Township Roubidoux
or
Village
or
City

Registration District No. 715 File No.
Primary Registration District No. 5944 Registered No.
(No. St. Ward)

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

2 FULL NAME Infant - (Starnes)

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
(Month) (Day) (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)

Filed 7/30 1915 REG-1070
Registrar John Myers

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26 1915
(Month) (Day) (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 9:15 P.M.

The CAUSE OF DEATH* was as follows:
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
(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 Marion DATE OF BURIAL 7-27-1915
20 UNDERTAKER John Myers ADDRESS Cockville

Original file, date JUL -- 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]

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 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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