

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 Jones  
Township Oliver or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
Registration District No. 860 File No. 23811  
Primary Registration District No. 6130 Registered No. 123  
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Infant (Billie)

| PERSONAL AND STATISTICAL PARTICULARS  |   |   | MEDICAL CERTIFICATE OF DEATH   |  |
|---|---|---|--|--|
| SEX<br><u>male</u>  | COLOR OR RACE<br><u>White</u>   | SINGLE MARRIED WIDOWED OR DIVORCED<br><input checked="" type="checkbox"/> <u>Single</u><br>(Write the word) | DATE OF DEATH<br><u>June 17, 1915</u><br>(Month) (Day) (Year)  |  |
| DATE OF BIRTH<br><u>May 17, 1915</u><br>(Month) (Day) (Year)  |   |   | I HEREBY CERTIFY, that I <u>attended</u> deceased from <u>did not attend</u> , to _____, 191____, that I last saw him alive on <u>date of birth</u> , 191____, and that death occurred, on the date stated above, at <u>10 P.M.</u> The CAUSE OF DEATH* was as follows:<br><u>Stomach and Bowel trouble supposed to be</u> |  |
| AGE<br>_____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?  |   |   | (Duration) _____ yrs. _____ mos. _____ ds.   |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |   |   | Contributory <u>liver and stomach</u><br>(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.  |  |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>mo</u>  |   |   | (Signed) <u>J. B. Cox</u> M. D.<br><u>June 18, 1915</u> (Address) <u>Omaha Ark</u>   |  |
| PARENTS   | NAME OF FATHER<br><u>W. R. Billie</u>                                       |   | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  |  |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Ark</u> |   | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)   |  |
|   | MAIDEN NAME OF MOTHER<br><u>Mollie McDonald</u>                             |   | At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.   |  |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Ark</u> |   | Where was disease contracted If not at place of death? _____   |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |   |   |  |  |
| (Informant) <u>W. R. Billie</u>   |   |   | Former or usual residence _____  |  |
| (ADDRESS) <u>Omaha Ark</u>  |   |   | PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____  |  |
| Filed <u>July 1, 1915</u> <u>R. B. Kite</u>   |   |   | UNDERTAKER _____ ADDRESS _____   |  |
|   |   |   | REGISTRAR  |  |

# 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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, 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.)



WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH  
 County Laney  
 Township Alvina  
 or  
 Village  
 or  
 City (NO. Inf St. (Buller) Ward)

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

Registration District No. 860 File No. \_\_\_\_\_

Primary Registration District No. 6130 Registered No. 123

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH June 17, 1915  
 (Month) (Day) (Year)

6 DATE OF BIRTH May 17, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I did not attend  
Satisfactory Information Supplied. deceased from  
 that I last saw him live on date of birth, 1915  
 and that death occurred, on the date stated above, at 10 P. m.

7 AGE 1 yrs. 1 mos. 0 da.  
 If LESS than 1 day... hrs. or... min.?

The CAUSE OF DEATH\* was as follows:  
Stomach & bowel trouble

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

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 CONTRIBUTORY liver & stomach  
 (Secondary)

9 BIRTHPLACE  
 (City or town, State or foreign country) Missouri

PARENTS  
 10 NAME OF FATHER W. R. Buller  
 11 BIRTHPLACE OF FATHER Ark.  
 (City or town, State or foreign country)  
 12 MAIDEN NAME OF MOTHER Molly McDonald  
 13 BIRTHPLACE OF MOTHER Ark.  
 (City or town, State or foreign country)

(Signed) T. G. Cox M. D.  
June 18, 1915 (Address) Omaha, Ark.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) W. R. Buller  
 (Address) Omaha, Ark.

\*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 \_\_\_\_\_

15 Filed 7/1 1915 R. P. Kit.  
 Registrar

19 PLACE OF BURIAL OR REMOVAL Omaha Ark DATE OF BURIAL June 18, 1915  
 20 UNDERTAKER X ADDRESS X

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

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

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183811  
*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 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 "Asthma," "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.)