

N. B.—Every item of information should be carefully supplied. DATE 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.

PLACE OF DEATH

County Lewis
 Township Linn
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 483
 Primary Registration District No. 5647

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

File No. 2154-A
 Registered No. 2

FULL NAME Lewis Bates

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH August 20, 1838
 (Month) (Day) (Year)

AGE 78 yrs. 4 mos. 19 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
 NAME OF FATHER Christopher Bates
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
 MAIDEN NAME OF MOTHER Lorah Barker
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Bates
 (ADDRESS) Williamstown Mo

Filed Jan. 11, 1916 P. W. Jennings
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 9, 1916
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 7, 1916, to Jan. 9, 1916, that I last saw him alive on Jan. 7, 1916, and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
82 A

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

(Signed) P. W. Jennings M. P.
Jan. 9, 1916 (Address) Williamstown 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 Providence Cem DATE OF BURIAL Jan. 11, 1916
 UNDERTAKER Ford & Gerth ADDRESS Williamstown

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.)



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.

1 PLACE OF DEATH
 County Lewis
 Township Lynn
 Village
 City (NO. St. Ward)

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. 483 File No.
 Primary Registration District No. Registered No. 2

2 FULL NAME Lewis Bates

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>M</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ (Write the word)	16 DATE OF DEATH <u>Jan. 9, 1916</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u></u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, that I attended deceased from <u>Jan. 9, 1916</u> to <u></u> , 191 <u>6</u> that I last saw him <u>on</u> <u>Jan. 9, 1916</u> and that death occurred, on the date stated above, at <u></u> m.	
7 AGE <u></u> yrs. <u></u> mos. <u></u> ds.		If LESS than 1 day <u></u> hrs. or <u></u> min.?	The CAUSE OF DEATH* was as follows: <u>Cerebral hemorrhage</u> <u>Apoplexy</u> <u>64</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u></u> (b) General nature of industry, business, or establishment in which employed (or employer) <u></u>			CONTRIBUTORY (Secondary) <u></u> (Duration) <u></u> yrs. <u></u> mos. <u></u> ds.	
9 BIRTHPLACE (City or town, State or foreign country) <u></u>			(Signed) <u>P. W. Jennings</u> M.D. <u>Jan 9, 1916</u> Address <u>Willington, Mo.</u>	
PARENTS	10 NAME OF FATHER <u></u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u></u> mos. <u></u> ds. In the State <u></u> yrs. <u></u> mos. <u></u> ds.	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u></u>		Where was disease contracted if not at place of death? <u></u>	
	12 MAIDEN NAME OF MOTHER <u></u>		Former or usual residence <u></u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u></u>		19 PLACE OF BURIAL OR REMOVAL <u>Catholic</u> 20 UNDERTAKER <u>Ford & Gerth</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u></u> (Address) <u></u>			DATE OF BURIAL <u>Jan. 11, 1916</u> ADDRESS <u></u>	
15 <u>April 10, 1916</u> <u>P. W. Jennings</u> Filed <u></u> Registrar <u></u>				

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]

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