

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

PLACE OF DEATH

County Monroe
Township Washington
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 582 File No. 11272
Primary Registration District No. 5780 Registered No. 27

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

FULL NAME Thomas Pollard Child

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male **COLOR OR RACE** White **SINGLE MARRIED WIDOWED OR DIVORCED** (Write the word)
DATE OF BIRTH Feb 7, 1916
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. 4 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) _____

DATE OF DEATH Mar 11, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 11, 1916, to Mar 10, 1916, that I last saw him alive on Mar 10, 1916, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorage
1605

BIRTHPLACE (City or town, State or foreign country) Monroe Co. Mo

(Duration) _____ yrs. _____ mos. 21 ds.

PARENTS
NAME OF FATHER Thomas Pollard
BIRTHPLACE OF FATHER (City or town, State or foreign country) Monroe Co
MAIDEN NAME OF MOTHER Anna Goff
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) J. P. Ferguson M. D. Mar 11, 1916 (Address) Hannibal Mo

*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)
At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

(Informant) Thos. Pollard
(ADDRESS) Hannibal Mo.

PLACE OF BURIAL OR REMOVAL _____ **DATE OF BURIAL** 9 1916

Filed Mar 21, 1916 H. C. Payne REGISTRAR

UNDERTAKER H. W. McBlair **ADDRESS** Hannibal 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, 8 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, 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 "Asihenia," "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 septicæmia," "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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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Monroe
 Township Washington
 or
 Village
 or
 City (NO. St. Ward)

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

Registration District No. 582 File No.
 Primary Registration District No. 5780 Registered No. 27

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

2 FULL NAME

Thomas Pollard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Mar 11 1916
 (Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191, that I last saw him alive on information, 191, and that death occurred, on the date stated above, at Supplied m.

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

The CAUSE OF DEATH* was as follows: Supplied

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

Cerebral Haemorrhage
Cause unknown
 (Duration) 64 yrs. 31 mos. 31 ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) A. E. Ferguson M. D. 3/11 1916 (Address) Advised

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)

*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 3/21 1916 H. E. Raper Registrar

19 PLACE OF BURIAL OR REMOVAL Churchwell mo DATE OF BURIAL 1916 20 UNDERTAKER G. W. McClure ADDRESS

SUPPLEMENTARY INFORMATION Supplied

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