

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

PLACE OF DEATH

County Polk
Township Polk
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 804 File No. 23341
Primary Registration District No. 5003 Registered No. _____

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

FULL NAME Roy Buchart

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE Married MARRIED Married WIDOWED OR DIVORCED (#rite the word)

DATE OF BIRTH Jan. 26, 1911
(Month) (Day) (Year)

AGE 05 yrs 5 mos 29 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) Macon Co. Mo.

PARENTS NAME OF FATHER Ralph Buchart BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany MAIDEN NAME OF MOTHER Barbara Lawson BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Buchart (ADDRESS) Greentop Mo

Filled June 23 1916 T. B. Farmington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 22, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1916, to June 22, 1916, that I last saw him alive on June 21, 1916,

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:
Meningitis Simple
79H 61
(Duration) ____ yrs. ____ mos. ____ ds.

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

(Signed) T. B. Farmington M. D. June 22 1916 (Address) Greentop 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 Front Madison DATE OF BURIAL June 24 1916

UNDERTAKER L. O. Young ADDRESS Greentop Mo.

This is a very important document. It may be used for legal classification.

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

County _____

Township _____ File No. _____
 or Village _____ Registered No. _____
 or Primary Registration District No. _____
 City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME

Frank J. ...

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	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)

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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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 _____ in.

The CAUSE OF DEATH* was as follows:

Contributory (secondary) _____ (Duration) _____ yrs _____ mos _____ ds.
 _____ (Duration) _____ mos _____ ds.
 (Signed) _____ (Address) _____ M. D.

* 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. State _____ 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
UNDERTAKER	ADDRESS

Filed _____ 191____ REGISTRAR

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

B.—Every item of information should be set carefully supplied, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and OCCUPATION is very 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 Bokeh
Township Bokeh
or
Village
or
City

Registration District No. 804 File No.
Primary Registration District No. 5003 Registered No.
St. Ward

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

2 FULL NAME Roy Buchart

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE If LESS than 1 day.....hrs. or.....min. yrs.....mos.....ds.

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 6 (Day) 22 (Year) 1916

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191 that I last saw him alive on 191 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH was as follows: Simple Meningitis non epidemic

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

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)

CONTRIBUTORY (Secondary) (Duration) yrs.....mos.....ds.

(Signed) F. B. Harrington M. D. 422, 1916 (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) (Address)

*State the Disease Causing Death, or, in death 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 6/23, 1916 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ADDRESS

20 UNDERTAKER

Original file, date JUN 1916

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 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 "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.)

23341

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

1 PLACE OF DEATH

County Schuyler
Township Boon
Village
City

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

Registration District No. 804 File No. 23341
Primary Registration District No. Registered No.
City (NO. St. Ward)

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

2 FULL NAME

Ray Buchart

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) 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) Albert Buchart
(Address) Greentown Mo

15 Filed June 23 1916 F. B. Farrington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22 1916
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Neuritis not epidemic
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. B. Farrington M. D.
June 22 1916 (Address) Greentown 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 Fort Madison Mo DATE OF BURIAL July 1 1916

20 UNDERTAKER L. O. Young ADDRESS Greentown Mo

SUPPLEMENTARY

Original file, date, 19

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

N. B.—Every file has a stamp for the CAUSE OF DEATH. If the cause of death is not stated, the certificate is void. PH. C. CUPA, State Hygienist, St. Louis, Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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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*; *Broncho-pneumonia* ("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 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 "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.)