

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

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

32237

1 PLACE OF DEATH

County *St. Francois*  
Township *Perry*  
or  
Village  
or  
City *Bonneton* (NO. .... St. .... Ward)

Registration District No. *775*  
Primary Registration District No. *697A*

File No. ....  
Registered No. *78*

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

2 FULL NAME *Malcomb Deewood White*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *single*

6 DATE OF BIRTH *July 27, 1915*  
(Month) (Day) (Year)

7 AGE *1* yrs. *1* mos. *20* ds. It LESS than 1 day, .... hrs. or .... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Bonneton Mo.*

PARENTS  
10 NAME OF FATHER *Richard White*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *St. Francois Co.*  
12 MAIDEN NAME OF MOTHER *Catherine Howell*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *St. Francois*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Richard White*  
(Address) *Bonneton Mo.*

15 Filed *Sept 17, 1916* Registrar *T. A. Son*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 16, 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Sept. 14, 1916* to *Sept. 16, 1916*, that I last saw him alive on *Sept. 16, 1916*, and that death occurred, on the date stated above, at *9-45 P.M.*

The CAUSE OF DEATH\* was as follows:  
*Menengitis from fall.*  
*1843*  
(Duration) .... yrs. .... mos. *3* ds.

CONTRIBUTORY (Secondary) *-*  
(Signed) *Deesley* M. D.  
*9-17, 1916* (Address) *Bonneton*

\*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 *Bonneton Cemetery* DATE OF BURIAL *Sept. 17, 1916*  
UNDERTAKER *R. A. Benson* ADDRESS *Bonneton Mo.*

# 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, 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 "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.)

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

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

1 PLACE OF BIRTH  
County St. Francois  
Township Perry  
or  
Village  
or  
City

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW  
Registration District No. 775 File No.  
Primary Registration District No. 6020 Registered No. 78  
(NO. St. Word)

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

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)  
Satisfactory Information Supplied.

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

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)

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)

15 Filed Oct 30 1916 T. A. Son  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
9-16-6  
(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  
The CAUSE OF DEATH\* was as follows:

Meningitis from fall  
Accidental fall  
To Floor. (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) 9-17-16 Lea Buckley M. D.  
Tommeterra (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 DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

SUPPLEMENTARY  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.

Original file, date AUG 7 1916

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

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[Approved by U. S. Census and American Public Health  
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32237  
FC22C

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