

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

PLACE OF DEATH
County Shelby
Township Shelbyville
or
Village Shelbyville
or
City _____ (NO. _____ St., _____ Ward)

Registration District No. 831 File No. 33250
Primary Registration District No. 4504 Registered No. 24

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

FULL NAME William H. Bell

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If "M" the word)

DATE OF BIRTH Apr. 12, 1830
(Month) (Day) (Year)

AGE 86 yrs. 4 mos. 30 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) r

BIRTHPLACE (City or town, State or foreign country) Mailey, Ky.

PARENTS
NAME OF FATHER James Bell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Elizabeth Eaton
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. West
(ADDRESS) Shelbyville, Mo.

Filed Sept 12 1916 W. C. Carver REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Aug 27, 1916, to Sept 14, 1916, that I last saw him alive on Sept 10, 1916, and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:
softening of brain
875
99 W (Duration) 1 yrs. x mos. x ds.
Contributory (SECONDARY) x yrs. x mos. x ds.

Signed P. C. Arches M. D.
Sept 12, 1916 (Address) Shelbyville, 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 Dick Dale mo DATE OF BURIAL Sept. 13, 1916

UNDERTAKER W. Thompson ADDRESS Shelbyville, Mo.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

Be carefully supplied. AGE should be stated EXACTLY. PHY. CAUSE OF DEATH should be stated in full. Every item of CAUSE OF DEATH should be stated in full.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____	(Month) _____ (Day) _____ (Year) _____	If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION _____	_____ yrs. _____ mos. _____ ds.	

(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) _____

Filed _____, 191_____

REGISTRAR

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

DATE OF DEATH _____ MEDICAL CERTIFICATE OF DEATH X328

(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:

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

Contributory (SECONDARY) _____

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

(Signed) _____

191____ (Address) _____ M. D. _____

*State the Disease Causing Death or, in deaths from Violent Cause, 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 _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

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

HTJ
 1 PLACE OF DEATH
 County Shelby
 Township
 or
 Village
 or
 City Shelbyville (NO. St. Ward)

Registration District No. 831 File No.
 Primary Registration District No. 4504 Registered No. 24

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

FULL NAME William H. Bell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

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

17 I HEREBY CERTIFY, that I attended deceased from
, 191..... to, 191.....

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

that I last saw him/her alive on, 191..... and that death occurred, on the date stated above, at, m.

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

The CAUSE OF DEATH* was as follows:

Softening of Brain
Arterio Sclerosis

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

(Duration) 1 yrs. 6 mos. 5 ds.

10 NAME OF FATHER

CONTRIBUTORY (Secondary)

11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

(Duration) yrs. mos. ds.

12 MAIDEN NAME OF MOTHER

(Signed) P. C. Archer M. D.
9/12 1916 (Address) Shelbyville Mo

13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

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

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 9/14 1916 W. H. Bell
 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

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

SUPPLEMENTARY

RECORD

SIANS should state ION is very important.

E PLAINLY, W

should be in pl. erms.

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, 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 "Asthemia," "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.)