

1 PLACE OF DEATH

County ClayTownship Fishing RiverVillage Excelsior SpringsCity Excelsior Springs (NO. Nebraska Hotel St. _____ Ward _____)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40347

Registration District No. 198

File No. _____

Primary Registration District No. 3011Registered No. 1012 FULL NAME Electra H. Cells

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (If Write Married)6 DATE OF BIRTH July 28, 1846
(Month) (Day) (Year)7 AGE 70 yrs. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General Farmer9 BIRTHPLACE (City or town, State or foreign country) Johnson Co Iowa10 NAME OF FATHER Don't Know11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know12 MAIDEN NAME OF MOTHER Don't Know13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Rogers(Address) New Market La15 Filed Dec. 12, 1916 T. N. Bogart
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 12, 1916
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from Nov. 24, 1916, to Dec. 12, 1916, that I last saw him alive on Dec 11, 1916, and that death occurred, on the date stated above, at 2:9, p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis - Complicated with typhus infection.

130 114 (Duration) - yrs. - mos. 5 ds.

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

(Signed) John J. Gaudin M. D. Dec. 12, 1916 (Address) Excelsior Springs 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. 12 ds. In the State yrs. mos. 12 ds.

Where was disease contracted if not at place of death? Do not knowFormer or usual residence New Market Iowa19 PLACE OF BURIAL OR REMOVAL New Market Iowa DATE OF BURIAL _____ 191____20 UNDERTAKER Brother & Hope ADDRESS Excelsior Springs

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 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.)

1 PLACE OF DEATH

County

Clay

Township

or

Village

or

City

Emelias Spg. (NO Nebraska Hotel)

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

Registration District No.

198

File No.

Primary Registration District No.

3011

Registered No.

101

Ward)

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

2 FULL NAME

Electrons T. Cells

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

(Month) (Day) (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)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME
OF MOTHER13 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 Dec. 12, 1916

T. M. Bogart
Registrar

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 12, 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:

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

191 (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

20 UNDERTAKER

ADDRESS

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
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