

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Marion

Township ~~Marion~~

Village Hannibal

City Hannibal

Registration District No. 547

Primary Registration District No. 3029

(NO. Oakwood St. Ward)

File No. 2. 6740

Registered No. 407

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

2 FULL NAME Thos. V. Bonaster

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Feb. 2, 1917
(Month) (Day) (Year)

6 DATE OF BIRTH May 30, 1880
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 17, 1917 to Feb. 2, 1917, that I last saw him alive on Feb. 2, 1917, and that death occurred, on the date stated above, at 9:00 a.m.

7 AGE 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Injury to Brain
Lacerated Brain

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

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) W. L. ... M. D. Feb. 3, 1917 (Address) Hannibal Mo

10 NAME OF FATHER J. H. C. Bonaster

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

12 MAIDEN NAME OF MOTHER Denicy Cook

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

*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.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Sam Bonaster (Address) Hannibal Mo

15 Filed Feb 3, 1917 Thos. B. Arnold Registrar

19 PLACE OF BURIAL OR REMOVAL Hannibal Mo DATE OF BURIAL Feb 4, 1917

20 UNDERTAKER Thos. M. Smith ADDRESS Hannibal 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*, *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 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.)

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

PLACE OF DEATH
Marion

Relationship
Neighbour

Registration District No. *547* File No. *6740*

Primary Registration District No. *3029* Registered No. *44*

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

FULL NAME *Wm J. Bauster*

PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE *W* 2 SINGLE MARRIED WIDOWED OR DIVORCED *M*
(Write the word)

3 AGE *37* yrs. *7* mos. *2* ds. If LESS than 1 day, hrs. or min.?

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

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

6 NAME OF FATHER

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

8 MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ (Address) _____

Filed *3/3* 191*7* *Wm J. Bauster* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *3/7* 191*7*
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Injury to Brain causing Hemorrhage. Brain was ruptured death due to hemorrhage 2/3

CONTRIBUTORY (Secondary) *Accident*
(Duration) _____ yrs. _____ mos. _____ ds.
Struck by train
W. Bauster M. D.
(Address) *503 Broadway*

*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 _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

20 UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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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), *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.)