

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

1 PLACE OF DEATH

County Clay
Township Freshing Basin Registration District No. 198 File No. 9617
or
Village _____ Primary Registration District No. 8011 Registered No. 37
or
City Excelsior Springs (NO. Cassmore Ave. St.; _____ Ward)

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

2 FULL NAME Glenwood Hullum

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>Mar 2nd 1901</u> (Month) (Day) (Year)		
7 AGE <u>16 yrs. 19 mos. 19 ds.</u>		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Auto chauffer</u> (b) General nature of industry business, or establishment in which employed (or employer) " " "		
9 BIRTHPLACE (City or town, State or foreign country) <u>Parkville Mo.</u>		
PARENTS	10 NAME OF FATHER <u>Beverly Hullum</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	12 MAIDEN NAME OF MOTHER <u>Nettie Nicholls</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Parkville</u>	

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 21 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 1 1916 to Mar 21 1917, that I last saw him alive on Mar 1 1917, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

CONTRIBUTORY (Secondary) Injury to Lungs
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. O. Keel M. D.
3/21 1917 (Address) Excelsior Springs Mo.

*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? Wagoner County Mo.
Former or usual residence Parkville Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruben Gray
(Address) Excelsior Springs

15 Filed 3-22 1917 T. M. Boyart
Registrar

19 PLACE OF BURIAL OR REMOVAL Parkville Mo. DATE OF BURIAL Mar 27 1917
20 UNDERTAKER Prather & 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.)

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BUREAU OF VITAL STATISTICS
MISSOURI STATE BOARD OF HEALTH

1 PLACE OF DEATH
City

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

CERTIFICATE OF DEATH

County *Clay* Registration District No. *198* File No. *37*
 Township *9* or Village *9* or City *9* (NO. *3011*) Primary Registration District No. *3011* Registered No. *37*
 St. *9* Ward *9*

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

2 FULL NAME
Glennwood Kullum

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *M* 4 COLOR OR RACE *B* 5 SINGLE MARRIED WIDOWED OR DIVORCED
 (Write the word) *D*
 6 DATE OF BIRTH *2-21-1917*
 (Month) (Day) (Year)
 7 AGE *27* yrs. *1* mos. *1* ds. If LESS than 1 day.....hrs. or.....min.?

16 DATE OF DEATH *Feb 21 1917*
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, that I attended deceased from *1917* to *1917*
 that I last saw h..... alive on *1917*
 and that death occurred, on the date stated above, at *1917* 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:
B. of hip struck by an automobile accident

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

CONTRIBUTORY (Secondary) *injury to hip*
 (Duration) yrs. mos. ds.
 (Signed) *B. J.* M. D.
 1917 (Address)

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) *9/34/17*
 (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.....

15 Filed *2/24/17* 1917
 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 20 UNDERTAKER ADDRESS

SUPPLEMENTARY

Original file, date *Feb 17*, 1917

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]

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