

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

1 PLACE OF DEATH
County Miller
Township Franklin
or
Village
or
City

Registration District No. 1041 File No. 15589
Primary Registration District No. 5751 Registered No. 10
City (NO. St. Ward)

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

2 FULL NAME A. N. Roark

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OF, DIVORCED (Write the word) married

16 DATE OF DEATH April 4th 1917
(Month) (Day) (Year)

6 DATE OF BIRTH Nov 18 1855
(Month) (Day) (Year)

17 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..... m.

7 AGE 61 yrs. 4 mos. 16 ds. IF LESS than 1 day..... hrs. or..... min.?

The CAUSE OF DEATH* was as follows:
Gun shot wound inflicted by himself
10/11 in S. Stephens St
acting criminally
(Duration)..... yrs..... mos..... ds.

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

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.
(Signed)..... M. D.
April 5, 1917 (Address) Eldon Mo

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

PARENTS
10 NAME OF FATHER James Roark
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Leah Vernon
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) 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..... 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) Mrs A. N. Roark
(Address) Eldon Mo.

15 Filed April 10, 1917 Scott Shirley Registrar

19 PLACE OF BURIAL OR REMOVAL Eldon County DATE OF BURIAL 4th 1917
20 UNDERTAKER W. Whalley's ADDRESS Eldon

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.

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, peritonacum*, 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

1 PLACE OF DEATH

County Miller
Township Franklin
or
Village
or
City (NO. 2 St. W. Ward)

Registration District No. 1041 File No. _____

Primary Registration District No. 5756 Registered No. 10

2 FULL NAME

J. N. R. Rook

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Apr 4 1917
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from _____ 1917 to _____ 1917
that I last saw him _____ alive on _____ 1917
and that death occurred, on the date stated above, at _____ m.

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

The CAUSE OF DEATH* was as follows:

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

Gun Shot Wound
Suicide
(Duration) _____ yrs. _____ mos. _____ ds.

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

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

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)

(Signed) J. S. Shepherd (Coroner)
4/5 1917 (Address) Edon, Mo.

*State the Disease Causing Death, or, in death 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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant) _____
(Address) _____

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 4/10 1917 J. S. Shepherd Registrar

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1917

20 UNDERTAKER _____ ADDRESS _____

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.

Satisfactory Information Supplied

