

## 1 PLACE OF DEATH

County Buchanan

Township \_\_\_\_\_

OR \_\_\_\_\_

Village \_\_\_\_\_

OR \_\_\_\_\_

City St. Joseph

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 37534Registration District No. 85File No. 57Primary Registration District No. 1001Registered No. 1213(NO. Noyes Hospital St. \_\_\_\_\_ Ward)

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

2 FULL NAME Robert Tribble

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single6 DATE OF BIRTH June 22, 1874.  
(Month) (Day) (Year)7 AGE 43 yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION (a) Trade, profession, or particular kind of work Farm Laborer.

(b) General nature of industry business, or establishment in which employed (or employer)

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

PARENTS	10 NAME OF FATHER <u>R I Tribble</u>
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown.</u>
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. O. Sidenfader(Address) 215 No. 10th St.15 Filed Nov 21, 1917 H. O. Slayton Registrar  
per Deputy

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 16, 1917  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I autopsied ~~attended~~ deceased from Nov. 19, 1917 to \_\_\_\_\_, 1917.that I last saw him alive on \_\_\_\_\_, 1917, and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH\* was as follows:

Erethmo Meningitis.  
175 B  
77 A(Duration) 11 yrs. 11 mos. 11 ds.CONTRIBUTORY Struck on head with rifle  
(Secondary)(Duration) 11 yrs. 11 mos. 11 ds.(Signed) Joseph Thomas Coroney M. D.Nov 20, 1917 (Address) 318 Phyp & Eng (2)

\*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 0 yrs. 0 mos. 2 ds. In the 43 yrs. 4 mos. 24 ds.Where was disease contracted if not at place of death? 1411 South 5th StFormer or usual residence Phillipsburg, MISSOURI19 PLACE OF BURIAL OR REMOVAL Phillipsburg, MO.DATE OF BURIAL Nov. 22, 1917.20 UNDERTAKER H. O. SidenfaderADDRESS 215 No. 10th St.

# 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.)

Township..... Registration District No. 85 File No.....  
 or.....  
 Village..... Primary Registration District No. 1001 Registered No. 1213  
 or.....  
 City..... (NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
**FULL NAME** Robert Zibbelle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
6 DATE OF BIRTH ..... (Month) ..... (Day) 1 ..... (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 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).....		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
 (Month) Nov (Day) 16 (Year) 1917

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. The CAUSE OF DEATH was as follows:  
Shot on head with rifle (Homicidal)

CONTRIBUTORY (Secondary) Struck on head with rifle  
 (Duration) ..... yrs. .... mos. .... ds.  
 (Signed) Forrest Thomas M. D. Coroner  
Jan. 6, 1918 (Address) 318 Phy & Duys Bldg

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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant).....  
 (Address).....  
 Filed Jan 9 1918 H. D. Lawator Registrar  
property

Original file, date Nov 21, 1917

All information called for must be written on this Supplementary Certificate.

Supplementary Information Supplied

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

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3753  
*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 "Asthena," "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.)