

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

**1 PLACE OF DEATH**

County Shelby  
Township Taylor  
or  
Village  
or  
City

Registration District No. 833  
Primary Registration District No. 6096

File No. 40256  
Registered No. 12

**2 FULL NAME**

Joseph L. Brubaker

(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 (Write the word) married

6 DATE OF BIRTH Aug 20 1849  
(Month) (Day) (Year)

7 AGE 68 yrs. 3 mos. 9 ds. If LESS than 1 day... hrs. or... min.?

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

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

10 NAME OF FATHER Joseph Brubaker

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

12 MAIDEN NAME OF MOTHER Katherine Sawyer

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) John G. Detweiler  
(Address) Cherry Box Mo

15 Filed Nov 30 1917 E. A. Gerard  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Nov 29 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 28 1917 to Nov 29 1917 that I last saw him alive on Nov 29 1917 and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage  
12:50 A.M.  
64

(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) 1 yrs. 1 mos. 1 ds.

(Signed) A. R. Goss M. D. Nov 30 1917 (Address) Cherry Box 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

19 PLACE OF BURIAL OR REMOVAL Memorial Park DATE OF BURIAL Dec 1 1917

20 UNDERTAKER Leon Smith ADDRESS Leonard 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, 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

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

County *Shelby*  
 Township *Taylor*  
 or  
 Village  
 or  
 City

Registration District No. *833* File No.  
 Primary Registration District No. *6096* Registered No. *12*  
 (NO. St. Ward)

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

2 FULL NAME

*Joseph Le Brubaker*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *m* 4 COLOR OR RACE *w.* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *m.*

16 DATE OF DEATH *Nov 29 1917*  
 (Month) (Day) (Year)

6 DATE OF BIRTH *Aug 20 1849*  
 (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 *68 yrs 3 mos 9 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 *Carpenter*  
 (b) General nature of industry, business, or establishment in which employed (or employer)

*Cerebral Hemorrhage.*

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

*Acute yellow atrophy of liver* (Duration) yrs. *1* mos. *25* ds.

10 NAME OF FATHER *Joseph Le Brubaker*

CONTRIBUTORY (Secondary) *Cerebral Hemorrhage* (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Penn*

(Signed) *E. P. Gossett* M. D. *Cherry Boro Mo.*

12 MAIDEN NAME OF MOTHER *Catherine Laeber*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) *18* yrs. *1* mos. *25* ds.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Penn*

At place of death yrs. mos. ds. In the State yrs. mos. ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death?

(Informant) *John G. Delivier*

Former or usual residence

(Address) *Cherry Boro Mo*

19 PLACE OF BURIAL OR REMOVAL *Mount Abrethian Cem* DATE OF BURIAL *Dec 1 1917*

15 Filed *Jan 28 1918* *E. N. Gerard* Registrar

20 UNDERTAKER *Leon Smith* ADDRESS *Leon Smith*

Original file, date *Nov 30 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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*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 "Asthma," "Anæmia" (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 septichaemia," "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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