LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr Roy

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

1 PLACE OF DEATH
County Shelby
Township or Village or City Clarence
Registration District No. 827
Primary Registration District No. 4560
File No. 3892
Registered No. 47
(NO. ..... St.; ..... Ward)
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elisha Abe Collison

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 Oct 28 (Month) (Day), 1861 (Year)
7 AGE 56 yrs. 2 mos. 11 ds.
If LESS than 1 day, ... hrs. or ..... min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) —
9 BIRTHPLACE (City or town, State or foreign country) Virg.
PARENTS
10 NAME OF FATHER Oscar Collison
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Virg
12 MAIDEN NAME OF MOTHER Margaret Bright
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virg
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Collison
(Address) Clarence Mo
15 Filed Feb 8, 1918 W. M. Bayliss Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 9 (Day), 1918 (Year)
17 I HEREBY CERTIFY, that I attended deceased from Dec 10, 1918, to Jan 9, 1918, that I last saw him alive on Jan 9, 1918, and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
87B Brain pressure
74
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Nurasthenia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frank R. Roy M. D.
Jan 10, 1918, (Address) Clarence, 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 Clarence Mo
DATE OF BURIAL Jan 11, 1918
20 UNDERTAKER E. E. Hopper
ADDRESS Clarence

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OU

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.; ..... Ward)

[If death hospital give its of street

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

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)

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) .....

(Address) .....

15

Filed ..... 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day)

17 I HEREBY CERTIFY, that I attended dec

....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent (1) Means of Injury; and (2) whether Accidental, Suicidal or

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

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

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURI

20 UNDERTAKER	ADDRESS

will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS

not 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"); *Diphteria*