

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

4704

1 PLACE OF DEATH  
County Warren  
Township .....  
or  
Village .....  
City Gallatin Mo. (NO. .... St. .... Ward)

Registration District No. 250 File No. ....  
Primary Registration District No. 4450 Registered No. 73

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

2 FULL NAME Thos Simeon Miller

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>Nov 18 1904</u> (Month) (Day) (Year)		
7 AGE <u>13</u> yrs. <u>3</u> mos. <u>15</u> ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>At Home</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Chickasha Wash</u>		
PARENTS	10 NAME OF FATHER <u>A. M. Miller</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Laverne Mo</u>	
	12 MAIDEN NAME OF MOTHER <u>Emmie Jones</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Cameron Mo</u>	

25 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Feb 27 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 12 1917 to Feb 26 1918, that I last saw him alive on Feb 24 1918, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:  
Blood Poison from wound in finger  
(Duration) ..... yrs. 1 mos. .... ds.

CONTRIBUTORY (Secondary) .....  
(Duration) ..... yrs. .... mos. .... ds.  
(Signed) B. G. Pitt M. D.  
Nov 7 1918 (Address) Gallatin

\*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) A. M. Miller  
(Address) Mo

15 Filed 3/2 1918 W. H. Prosser Registrar

19 PLACE OF BURIAL OR REMOVAL  
Local Burial

DATE OF BURIAL  
March 1918

20 UNDERTAKER  
J. M. Petty

ADDRESS  
Gallatin 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, 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, peritoneum*, 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.)

1 PLACE OF DEATH

County Andrew

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

Township \_\_\_\_\_

Registration District No. 250

File No. \_\_\_\_\_

or

Village \_\_\_\_\_

Primary Registration District No. 4150

Registered No. 73

or

City Gallatin

(No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

2 FULL NAME

N<sup>m</sup> Benson Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE 2 MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH November 18 1904  
(Month) (Day) (Year)

7 AGE 13 yrs. 3 mos. 9 ds. If LESS than 1 day... hrs. or... min.?

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

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

10 NAME OF FATHER A. H. Miller

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

12 MAIDEN NAME OF MOTHER Jessie Jones

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. H. Miller  
(Address) Gallatin - Missouri

15 Filed Apr 8 1918 W. H. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb - 27 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 17 1917 to Feb 27 1918 that I last saw him alive on Feb 26 1918 and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH was as follows:  
Blood Poison from Wound in finger  
Accidental Wound in blood

18 DURATION (Duration) 1 yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) 1 yrs. 1 mos. 17 ds.

(Signed) B. E. Schiffert M. D.

Apr 8 1918 (Address) Gallatin

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

At place of death 1 yrs. 1 mos. 17 ds. In the State 1 yrs. 1 mos. 17 ds.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Civil Bend Missouri DATE OF BURIAL March 1 - 1918

20 UNDERTAKER A. H. Pettigrew ADDRESS Gallatin Mo.

# 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 inter-current) 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 "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.)