

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

1 PLACE OF DEATH

County Marion
Township Liberty
or ~~Woodland~~
Village ~~Woodland~~
or
City (NO. _____) St. _____ Ward _____

Registration District No. U-48
Primary Registration District No. 5140

File No. 9813
Registered No. 26

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

2 FULL NAME Robert L. Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 1st 1917
(Month) (Day) (Year)

7 AGE 70 yrs 8 mos 25 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) SS

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

PARENTS
10 NAME OF FATHER Eliza Hall
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eliza Hall, J.B.
(Address) Woodland

15 Filed March 25-1918 Registrar J. Sanford

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 25- 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 20th 1918 to Mar 25th 1918, that I last saw her alive on March 20th 1918, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
abscess burst in side of neck
(Duration) 1 yrs. 4 mos. 4 ds.

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

(Signed) J. B. Rushenburgh M. D.
March 25 1918 (Address) Palmyra 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 Woodland, Mo DATE OF BURIAL March 25, 1918

20 UNDERTAKER Quest + Lewis ADDRESS Palmyra 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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Marion
Township Liberty
or
Village
or
City

Registration District No. 548 File No.
Primary Registration District No. 5740 Registered No. 216
St.: Ward)

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

FULL NAME Robert L. Hall

PERSONAL AND STATISTICAL PARTICULARS

DR. S. L. MYR

COLOR OR RACE W B

SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

AGE OF BIRTH
(Month) (Day) (Year)

SEX M

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

BIRTHPLACE
City or town, State or foreign country

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 25, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11:44 a.m., 1918, to 11:44 a.m., 1918, that I last saw him alive on May 25, 1918, and that death occurred, on the date stated above, at 11:44 a.m.

The CAUSE OF DEATH* was as follows:
Apexes bursted side of neck
See notes attached

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) J. C. Lockmanbaugh M. D.
Marion, Mo. (Address) Palmyra, Mo.

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

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

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

UNDERTAKER ADDRESS

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)

(ADDRESS)

dated May 15, 1918 S. Sanford REGISTRAR

Revised United States Standard Certificate of Death

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

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9813

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.)