

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

PLACE OF DEATH
County Merion
Township _____
or
Village Fairview
or
City _____ (No. _____) St. _____ Ward _____

Registration District No. 608 File No. _____
Primary Registration District No. 4362 Registered No. 9928

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

FULL NAME W. B. Davis

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>✓</u>	
DATE OF BIRTH <u>Mar 14</u> 18 <u>33</u> (Month) (Day) (Year)			
AGE <u>85</u> yrs. <u>11</u> mos. <u>3</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>			
BIRTHPLACE (City or town, State or foreign country) <u>Bonaco Tenn</u>			
PARENTS	NAME OF FATHER <u>Thomas</u> ✓		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>		
	MAIDEN NAME OF MOTHER <u>Bleum</u> ✓		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Mar 17</u> 191 <u>8</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>March 1</u> , 191 <u>8</u> , to <u>one visit only</u> , 191 <u>8</u> , that I last saw him alive on <u>March 1</u> , 191 <u>8</u> , and that death occurred, on the date stated above, at <u>8:30 am</u> . The CAUSE OF DEATH* was as follows: <u>Saw him once on</u> <u>Mar 1st 1918</u> <u>Old age</u> (Duration) <u>12</u> mos. ___ ds.	
Contributory (SECONDARY) (Signed) <u>P. L. Reeland</u> M. D. <u>Mar 18</u> , 191 <u>8</u> . (Address) <u>Fairview Mo</u> (Duration) ___ yrs. ___ mos. ___ ds.	
*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.	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Davis
(ADDRESS) Fairview Mo
Filed Mar 18th 1918 L. N. Parnell
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Sibercherry
UNDERTAKER
White & Parnell
DATE OF BURIAL
Mar 19, 1918
ADDRESS
Fairview Mo

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED DIVORCED (If give the word)
	DATE OF BIRTH	(Month) _____, 191____ (Year)

AGE _____ yrs. _____ mos. _____ ds. _____ (If LESS than 1 day, _____ hrs. or _____ min.?)

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) 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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (Year)

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 _____, in _____, The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____

Contributory
(SECONDARY) _____

_____ (Duration) _____ yrs. _____ mo.

(Signed) _____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN. RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

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

1 PLACE OF DEATH
County Newton
Township Franklin
or
Village Fairview
or
City Fairview

Registration District No. 608 File No. _____
Primary Registration District No. 4362 Registered No. 7
St.: _____ Ward) _____

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

2 FULL NAME Mylic B. Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M
4 COLOR OR RACE W
5 SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word) Widowed
6 DATE OF BIRTH May 14th 1833
(Month) (Day) (Year)
7 AGE 85
yrs. Infant mos. 3 ds.
If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE
(City or town, State or foreign country) Boone Tenn

PARENTS
10 NAME OF FATHER Thomas
11 BIRTHPLACE OF FATHER Missouri
12 MAIDEN NAME OF MOTHER Glen
13 BIRTHPLACE OF MOTHER Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. P. Davis
(Address) Fairview

15 Filed Mar 18 1918 L. N. Parnell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17 1918
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from Mar 17 1918 to 1918,
that I last saw him/her on March 1st 1918,
and that death occurred, on the date stated above, at 8:30 m.
The CAUSE OF DEATH* was follows:
Satisfactory Information Supplied

CONTRIBUTORY (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) P. C. Ireland M. D.
March 18 1918 (Address) _____

*State the Disease Causing Death, or, in death 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 _____ DATE OF BURIAL March 19 1918

20 UNDERTAKER White & Poque ADDRESS Fairview

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, 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 "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.)