

1 PLACE OF DEATH

County LivingstonMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13855

Township.....
orRegistration District No. 008

File No.

Village.....
orPrimary Registration District No. 3026Registered No. 48City Chillicothe (NO.....
St.;.....
Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Fountain Lee Gull

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE
~~MARRIED~~ single
~~WIDOWED~~
~~OR SEPARATED~~
(If ~~Widowed~~ or ~~separated~~)6 DATE OF BIRTH March 12 1903
(Month) (Day) (Year)7 AGE 15 yrs. 0 mos. 25 ds. If LESS than
1 day.....hrs.
or.....min.?8 OCCUPATION (a) Trade, profession, or
particular kind of work School
(b) General nature of industry
business, or establishment in
which employed (or employer) "9 BIRTHPLACE
(City or town,
State or foreign country) Chillicothe10 NAME OF FATHER N.B. Gull11 BIRTHPLACE OF FATHER
(City or town, State or foreign country) Chillicothe Mo12 MAIDEN NAME OF MOTHER Mary F. Willard13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Chillicothe Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N.B. Gull(Address) Chillicothe Mo15 Filed Apr 9 1918 J.C. Shelton
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 7 1918
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from
Mar 3 1918 to April 7 1918
that I last saw him alive on April 5 1918
and that death occurred, on the date stated above, at 1 1/2 m.

The CAUSE OF DEATH* was as follows:

Meningitis
18
119
(Duration) yrs..... mos..... ds.CONTRIBUTORY (Secondary) Ho Grippe
(Duration) yrs..... mos..... ds.(Signed) William Barnett M.D.
49 1918 (Address) Chillicothe Mo*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.19 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 Edgewood Cemetery DATE OF BURIAL 4-9 191820 UNDERTAKER Frank B. Norman ADDRESS Chillicothe 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

County Livingston

Township _____ or _____

Village _____ or _____

City Chillicothe (NO. _____ St. _____ Ward _____)

Registration District No. 508

File No. _____

Primary Registration District No. 3026

Registered No. 48

2 FULL NAME

Faustian Lee Gill

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ 1 _____
(Month) (Day) (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) _____

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 July 11, 1918 J. C. Shultz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 7, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above _____ m.

The CAUSE OF DEATH* was as follows:
Measles
Epidemic probably
L. Gripe

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

(Signed) Dr. Barney H. Shultz M. D.
July 11, 1918 (Address) Chillicothe, Mo.

*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 _____ 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 _____, 191____

20 UNDERTAKER _____ ADDRESS _____

Statutory Informator Supplied.

Statutory Informator Supplied.

X

Revised United States Standard Certificate of Death

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

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"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 child-birth 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.)