

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County *Shelby*
Township
Village *Bellevue Mo*
City (NO. St. Ward)

Registration District No. *827*
Primary Registration District No. *4500*

File No. *19207*
Registered No. *58*

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

2 FULL NAME

John H Abbott

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *May 10 1918*
(Month) (Day) (Year)

DATE OF BIRTH *June 23 1840*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *May 10 1918* to *May 10 1918*, that I last saw him alive on *May 11 1918* and that death occurred, on the date stated above, at *6:30 P.M.*

AGE *77 yrs 10 mos 17 ds.*
If LESS than 1 day.....hrs. or.....min.?

The CAUSE OF DEATH* was as follows:
20719
Struck by freight train
Concussion of brain
(Duration) yrs mos ds.

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

CONTRIBUTORY (Secondary) *Frank H Roy*
(Duration) yrs mos ds.
(Signed) *May 10 1918* (Address) *Clenden, Mo*

BIRTHPLACE (City or town, State or foreign country) *Ohio*

PARENTS
10 NAME OF FATHER *Robert J Abbott*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *N.Y.*
12 MAIDEN NAME OF MOTHER *Lucy Kryger*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Baumgard*

*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) *Miss Mary Abbott*
(Address) *Bellevue*

19 PLACE OF BURIAL OR REMOVAL *Bellevue Mo* DATE OF BURIAL *5/11 1918*
20 UNDERTAKER *E. E. Hopper* ADDRESS *Bellevue Mo*

5 Filed *May 16 1918* *S. W. H. Baylis* Registrar

LOCAL REGISTRAR'S RECORD--DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS 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 occurred
 hospital or institu
 give its NAME ins
 of street and numb

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) 191 (Year)
 7 AGE yrs. mos. ds.
 If LESS than 1 day hrs. or min.?

8 OCCUPATION (e) Trade, profession, or particular kind of work
 (h) 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 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year)
 17 I HEREBY CERTIFY, that I attended deceased for 191 to 191
 that I last saw h alive on 191
 and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. mos.
 (Signed) (Duration) yrs. mos.
 191 (Address) M.

*State the Disease Causing Death, or, in deaths from Violent Causes, an (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)
 At place of death yrs. mos. ds. In the State mos.
 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

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

1. PLACE OF DEATH

County Shelby Registration District No. 827 File No. 19207
 Township Clarence Primary Registration District No. 4500 Registered No. 3
 City Clarence (No.) St. Ward

2. FULL NAME

(a) Residence. No. St. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 5-16-18 W. M. Keyless REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1918

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Struck by freight train
compression of brain
Accidental,

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

170

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Frank K. Roy M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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, 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates 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
BY PHYSICIAN.