

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

1 PLACE OF DEATH

County Barren  
Township Nashville  
or  
Village  
or  
City

Registration District No. 46 File No. 28651  
Primary Registration District No. 5069 Registered No.

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

2 FULL NAME

Chas. L. Cotton (NO. St. Ward)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 15 1897  
(Month) (Day) (Year)

7 AGE 70 yrs. 10 mos. 22 ds. I LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Arkansas

10 NAME OF FATHER G. T. Cotton  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kansas  
12 MAIDEN NAME OF MOTHER Lillie M. Pugh  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) G. T. Cotton  
(Address) Nashville Mo.

15 Filed Sept 10 1918 Charles J. Brown Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 25, 1918, to Sept 6, 1918, that I last saw him alive on Sept 6, 1918, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Lagrippe  
(Duration) yrs. mos. 12 ds.

(Signed) J. H. Williams M. P.  
Sept 12, 1918. (Address) Nashville 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 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 Nashville Com. DATE OF BURIAL Sept 7, 1918

UNDERTAKER Chas. E. Traber ADDRESS Billsburg Kan.

CAUSE OF DEATH in plain terms, so that it may be properly classified. - Write on separate sheet if necessary.

**I PLACE OF DEATH**

County .....  
 Township .....  
 or .....  
 Village .....  
 or .....  
 City ..... (NO

Registration District No. .... File No. ....  
 Primary Registration District No. .... Registered No. ....  
 St. .... Ward)

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

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

**2 FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX  SINGLE  MARRIED  WIDOWED  OR DIVORCED (Write the word)

6 DATE OF BIRTH ..... (Month) ..... 1 (Day) ..... 1 (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 ..... 191..... Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH ..... (Month) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to ..... 191..... that I last saw him ..... alive on ..... and that death occurred, on the date stated above, at ..... The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds. (Signed) ..... (Duration) ..... yrs. .... mos. .... ds. .... M. D.

\*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 ..... 191.....

20 UNDERTAKER ..... ADDRESS .....

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

1. PLACE OF DEATH  
 County Benton Registration District No. 46 File No. ....  
 Township Nashville Primary Registration District No. 5069 Registered No. ....  
 City (No. ....) St. .... Ward ....

2. FULL NAME Chas. L. Cotter  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 6 1918

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

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Leobar  
 (duration) yrs. .... mos. .... ds.

8. OCCUPATION OF DECEASED

CONTRIBUTORY (SECONDARY) La Grippe  
 (duration) yrs. .... mos. .... ds.

- (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

18. WHERE WAS DISEASE CONTRACTED

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

IF NOT AT PLACE OF DEATH, .....

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

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

WAS THERE AN AUTOPSY?.....

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS?

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

(Signed) J. H. McKeown, M. D.

14. INFORMANT (Address)

Sept 7, 1918 (Address) Nashville Mo

\*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.)

15. Sept 10, 1918 Claude F. Brouck  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

SUPPLEMENTARY INFORMATION CERTIFICATE

# 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

528982  
"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.