

1 PLACE OF DEATH.

County ButlerTownship Gillis Bluff

Inc. Town \_\_\_\_\_

City \_\_\_\_\_

STATE OF ARKANSAS No.

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

33637

Registration District No. 4289

File No. \_\_\_\_\_

Primary Registration District No. 5137

Registered No. \_\_\_\_\_

(No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

2 FULL NAME

Robert Shurt

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 (Write the word) \_\_\_\_\_6. DATE OF BIRTH 12-29-1922  
Month Day Year7. AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min?8. OCCUPATION (a) Trade, profession, or particular kind of work X (b) General nature of industry, business, or establishment in which employed (or employer) X9. BIRTHPLACE (State or Country) Butler Mo.

## PARENTS

10. NAME OF FATHER Will Shurt11. BIRTHPLACE OF FATHER (State or Country) Ill12. MAIDEN NAME OF MOTHER Brown13. BIRTHPLACE OF MOTHER (State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Shurt(Address) Laguer Mo.15. Filed 1/3 1923 W. L. Bailey REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12-24, 19\_\_\_\_  
Month Day Year17. I HEREBY CERTIFY That I attended the deceased from X, 19\_\_\_\_, to X, 19\_\_\_\_, that I last saw his alive on 12-14 1922, and that death occurred on the date stated above, at \_\_\_\_\_ m.The CAUSE OF DEATH \* was as follows:  
He had been assaulted with instrument in delivery  
160 B Duration \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.Contributory SECONDARY B Duration \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Signed W. L. Bailey M. D.  
12-25, 1922 Address Pallard Ark

\*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 Gillis Mo. DATE OF REMOVAL 12-25, 192220. UNDERTAKER J. G. Russell ADDRESS Pallard

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

**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 of 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 septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL 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 statements of cause of death approved by Committee on Nomenclature of the American Medical Association.)