

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

~~36354~~

1. PLACE OF DEATH

County Shannon
 Township Newton
 City..... (No. St. Ward)

Registration District No. 1125
 Primary Registration District No. 6082

File No. 36354 B
 Registered No.

2. FULL NAME

Leonard Faril Atchison

(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 ♂ 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 21 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
0 3 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) 00
 (c) Name of employer

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

PARENTS

10. NAME OF FATHER George Atchison

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

12. MAIDEN NAME OF MOTHER Francis Howard

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

14. INFORMANT Ray Weese
 (Address) Emb. Mo.

15. FILED Nov 29 1922 Camilla Gray
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1922

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Dec 27, 1922 that I last saw h. alive on 26, 1922, and that death occurred, on the date stated above, at Dec 27 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Unknown

2023
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

19. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Y. ..., 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 HOICIDAL. (See reverse side for additional space.)

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

Smith Cemetery Dec 29 1922

20. UNDERTAKER Ray Weese ADDRESS Emb. Mo.

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.

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, peritoncum*, 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.

1 PLACE OF DEATH

County ShannonTownship Newton

Village _____

City _____ (No. _____)

1125 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
6087 STANDARD CERTIFICATE OF DEATH

January

State of _____

Registered No. _____

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

2 FULL NAME

Leonard Paril Atchison

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

M

4 COLOR OR RACE

W5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(If Write the word)S

16 DATE OF DEATH

XDec
(Month)29, 1922
(Day) (Year)

6 DATE OF BIRTH

Sept 21
(Month) (Day)1911
(Year)

17

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 _____ m.

The CAUSE OF DEATH* was as follows:

7 AGE

_____ yrs. 3 mos. 6 ds.If LESS than
1 day, ____ hrs.
or ____ min.?_____
(Duration) _____ yrs. _____ mos. _____ ds.

8 OCCUPATION

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

(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory
(SECONDARY)_____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____, M. D.

_____, 191____ (Address) _____

* 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 _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____, 191____

20 UNDERTAKER

ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed Dec 30, 1922 Camilla Drough
REGISTRAR

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