

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

3831

1. PLACE OF DEATH

County Benton Registration District No. 60 File No. 7
 Township White Primary Registration District No. 5095 Registered No. 136
 City Lincoln (No. _____) St. _____ Ward _____

2. FULL NAME

Frank Ernest Tubbright

(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 male 4. COLOR OR RACE White 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) _____

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>12</u>			<u>29</u>	

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) Wagoner Kan
 (STATE OR COUNTRY)

10. NAME OF FATHER Robert Tubbright

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

12. MAIDEN NAME OF MOTHER Mary Jones

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

14. INFORMANT Robert Tubbright
 (Address) Lincoln Mo

15. FILED 7/22, 1923 Creuk. Cuddy
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9- 1923

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1923 to Feb 9th 1923 that I last saw him alive on Feb 9, 1923, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

(duration) _____ yrs. _____ mos. 21 ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH.

801 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) M. D. Sels, M. D.

, 19 _____ (Address) Wagoner 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.)

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

Lincoln Mo _____ 1923

20. UNDERTAKER _____ ADDRESS _____

J. B. Callister _____

PARENTS

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

"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 neoplasma); *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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Benton ⁶⁰ 5095 State MISSOURI. Registered No. _____
 Township White or Village _____ of _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank E. Rabright
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan 10 1893

7 AGE Years _____ Months _____ Days 29 IF LESS than
12 day hrs. _____ 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 7/12, 1923 Orren L. Biddy
11-2184 RE 2187

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

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:

CONTRIBUTORY (SECONDARY) _____
(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) _____, M. D.

, 19 (Address)

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

20 UNDERTAKER _____ ADDRESS _____

CAUSE OF DEATH IN plain terms, so that it may be properly classified. TION is very important. -See instructions on back of certificate.

SUPPLEMENTARY

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