

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

6295

1. PLACE OF DEATH
 County St Clair Registration District No. 769 File No. _____
 Township Sparkwell Primary Registration District No. 6015 Registered No. 9
 City _____ No. _____ St. _____ Ward _____

2. FULL NAME Robert Thomas Brackridge
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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) Oct-25-1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 4 | 1 | _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) 10 years
 (c) Name of employer _____

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

10. NAME OF FATHER James M Brackridge

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

12. MAIDEN NAME OF MOTHER Mary N Burch

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

14. INFORMANT Chas Brackridge
 (Address) Tiffin, Mo

15. FILED 228 19 W. J. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2nd 1900 1900

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1923, to Feb 2nd 1923, 1923, that I last saw him alive on Feb 17th 1923, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral death occurring from cerebral weakening.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) 5 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____
 CAN AN OPERATION PRECEDE DEATH? No DATE OF X
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Inspection Physical Reg.
 (Signed) J. W. Richardson, M. D.
Feb 26, 1923 (Address) Tiffin 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 Resant Cross DATE OF BURIAL Feb 19 1923

20. UNDERTAKER M. P. Swann, Ed. J. App. ADDRESS 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.

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECORDS DEPARTMENT
EXACTLY
RECORDED

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 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 "Asthemia," "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

BUREAU OF THE CENSUS

Feb. 1923

1 PLACE OF DEATH
 County St. Clair State MISSOURI 769 Registered No.
 Township Bedwell or Village 6015 or
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Thomas Brackenridge
 (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. _____
 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 A
(write the word)

16 DATE OF DEATH (month, day, and year) Feb 26 1923

6a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____,

6 DATE OF BIRTH (month, day, and year) Oct 26 1884

and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

7 AGE Years 38 Months 4 Days 1
If LESS than 1 day, hrs. _____ of min. _____

apoplexy death occurring from cerebral weakening

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) 10 years
 (c) Name of employer _____

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

9 BIRTHPLACE (city or town) _____ (State or country) _____

18 Where was disease contracted if not at place of death? _____ Did an operation precede death? _____ Date of _____

10 NAME OF FATHER James M. Brackenridge

Was there an autopsy? _____

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

What test confirmed diagnosis? _____ (Signed) _____, M. D.

12 MAIDEN NAME OF MOTHER Mary Busch

.19 (Address) _____

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country) _____

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14 Informant Chas Brackenridge (Address) Liddin Mo

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

15 Filed 4 25 1923 W. Edanson REGISTRAR
 11-2194

SUPPLEMENTAL

V. B. No. 68 N. B.--WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. 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.

MARGIN RESERVED FOR BINDING

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[Approved by U. S. Census and American Public Health Association]

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11-3184

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BY PHYSICIAN.

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