

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

80003

1. PLACE OF DEATH

County Shelby Registration District No. 831 File No. _____
 Township Shelbyville Primary Registration District No. 4504 Registered No. 9
 City Shelbyville St. 1 Ward _____

2. FULL NAME William Lewis Burkes

(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) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 None 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (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) Virginia

PARENTS

10. NAME OF FATHER W. Warren Burkes

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

12. MAIDEN NAME OF MOTHER Magie Gantt

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

14. INFORMANT (Address) Sallie J. Burkes Lakeview Mo

15. FILED Feb 23 1923 Hallie Bidgood REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1922, to Feb 16 1923 that I last saw him alive on Feb 16 1923, and that death occurred, on the date stated above, at 10 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

(duration) 5 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? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) Dr. J. M. Gantt, M. D.

, 19 (Address) Shelbyville 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

Stoutsville Mo 2-19 1923

20. UNDERTAKER

J. H. Thompson Son Shelbyville Mo

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 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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Shelby State MISSOURI 831 Registered No. _____
 Township _____ or Village 4507 or _____
 City Shelbyville No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Lewis Burks
 (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 16 DATE OF DEATH (month, day, and year) Feb 16 1923
 17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____,

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1867 and that death occurred, on the date stated above, at _____ m.

7 AGE Years Months Days 56 0 5 if LESS than 1 day - hrs. or - min. The CAUSE OF DEATH* was as follows:

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

9 BIRTHPLACE (city or town) (State or country) _____
 18 Where was disease contracted If not at place of death? _____

10 NAME OF FATHER _____ Did an operation precede death? _____ Date of _____
 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 _____, 19 (Address) _____

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

14 Informant (Address) _____ 19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL _____ 19

15 Filed Feb 17 1923 Hallie Bidgood 20 UNDERTAKER ADDRESS _____
 11-3184 REGISTRAR

SUPPLEMENTAL

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

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11—3154

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BY PHYSICIAN.

292