

PLACE OF DEATH

County Stoddard
 Township Pike
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

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

3308

Registration District No. 834 File No. 52
 Primary Registration District No. 6097 Registered No. 37

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

FULL NAME

Tom Bachelor

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widowed</u>
DATE OF BIRTH <u>Do not know</u> <u>1852</u> (Month) (Day) (Year)		
AGE <u>72</u> yrs. ____ mos. ____ ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

BIRTHPLACE (City or town, State or foreign country) <u>mo</u>
NAME OF FATHER <u>do not know</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>2</u>
MAIDEN NAME OF MOTHER <u>do not know</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>do not know</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Bachelor
 (ADDRESS) Kennett, Mo. R.I.

Filed 1-23-1924 W. Metcalfe
 REGISTAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 22, 1924
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191, to _____, 191,
 that I last saw h_____ alive on 12-10, 1923,
 and that death occurred, on the date stated above, at 4:30 P.M.
 The CAUSE OF DEATH* was as follows:

Tuberculosis
(I saw him 1 time a bout 12 months 12/23 of '23)
 (Duration) yrs. 2 mos. ____ ds.

Contributory _____
 (SECONDARY) (Duration) yrs. ____ mos. ____ ds.
 (Signed) OR Bachelor M. D.
1-23-1924 (Address) Admission, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL <u>Rocky Point, Mo</u>	DATE OF BURIAL <u>1-23</u> , 19 <u>24</u>
UNDERTAKER <u>Wm. Bachelor</u>	ADDRESS <u>Kennett, Mo</u>

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

City _____ (NO. _____)

St. _____

Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (If <i>write</i> the word)
DATE OF BIRTH _____	(Month) _____ / (Day) _____ / (Year) _____	

AGE _____ yrs. _____ mos. _____ ds.
 IF LESS than
 1 day, _____ hrs.
 or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

191_____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased # _____

_____ 191_____ to _____ 191_____

that I last saw h_____ alive on _____ 191_____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH^y was as follows:

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

Contributory (SECONDARY)

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

(Signed) _____

_____ 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.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 191_____

UNDERTAKER _____

ADDRESS _____

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

1. PLACE OF DEATH

County Stoddard Registration District No. 834 File No. 52
 Township Pike Primary Registration District No. 6097 Registered No. 37
 City No. _____ St. _____ Ward _____

2. FULL NAME

Tom Bachelor

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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 (write the word) Single

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 1852

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

7. 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 _____

BIRTHPLACE (CITY OR TOWN) _____
 OR COUNTRY _____

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT _____
 (Address) _____

15. FILED 3-13-19-24 N. McKeary REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 1924

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Tuberculosis of lungs

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) _____

*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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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, 8 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.