

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

Do not use this space.

36870 *af*

File No. 3-
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Shelby Registration District No. 830
Township Salt River Primary Registration District No. 6091
City Shelbina (No. _____) _____

2. FULL NAME

Alan Bell
(a) Residence No. _____ (Usual place of abode) _____ St. _____ Ward _____
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 4 - 1854</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>5</u>
	DAYS <u>26</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1924

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1924 to Dec 20, 1924 that I last saw him alive on Dec 30, 1924, and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
1924
1924
1924
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Fracture of Femur
(duration) _____ yrs. _____ mos. _____ da.

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

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Dec 27 - 24

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. A. Turner, M. D.
, 19 _____ (Address) Shelbina, 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.)

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Clark Co. Ill

10. NAME OF FATHER Burr Bell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Clark Co. Ill.

12. MAIDEN NAME OF MOTHER Emeline Pratt

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

14. INFORMANT Mrs Gay Flemer
(Address) Ashtonville Ill.

15. Feb 25 Madge Good
FILED _____ REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Palmyra

20. UNDERTAKER Peter + Vandiver

DATE OF BURIAL Jan 5 1925
ADDRESS Shelbina 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) *Colton 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.

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

1. PLACE OF DEATH

County Shelby Registration District No. 830 File No. _____
 Township Ball-River Primary Registration District No. 6091 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Dan Bell

(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 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 4 - 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 5 26

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Merchant
 (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) Ill.

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT Mrs Gay Flemer (Address) Ash Grove, Ill.

15. FILED Feb 20 1925 Wedge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 - 1924

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Bronchi

CONTRIBUTORY (SECONDARY) Fracture of Femur
Fell Down (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. Yes 185

DID AN OPERATION PRECEDE DEATH. Yes DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS. Clinical

(Signed) _____, 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

20. UNDERTAKER ADDRESS

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SUPPLEMENTARY

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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