

OCT 24 1927

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

26369

1. PLACE OF DEATH

County.....**ADAIR**.....
Township.....
City.....**NOVINGER MO**..... (No.....)

Registration District No.....**2**.....
Primary Registration District No.....**4004**.....

File No.....
Registered No.....**22**.....
St..... Ward.....

2. FULL NAME **ALBERT TRUITT**

(a) Residence. No.....**NOVINGER**..... 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 **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 **CARRIE TRUITT,**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **JAN 27th 1861**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 7 13

8. OCCUPATION OF DECEASED **BLACK SMITH**

(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 **SELF**

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) **MACON MO**

10. NAME OF FATHER **ELISA TRUITT,**

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) **OHIO XXXX MY**

12. MAIDEN NAME OF MOTHER **BERVA ROBERSON**

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

14. INFORMANT **Carroll Truitt**
(Address) **NOVINGER MO.**

15. FILED **Sy 17 1927** **J.S. Lashwell**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **9-12 1927**

17. I HEREBY CERTIFY That I attended deceased from **Aug 21** to **Sept 12** 19**27** that I last saw **alive** on **Sept 11** 19**27**, and that death occurred, on the date stated above, at **12:00** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
12:00
9:12

CONTRIBUTORY (SECONDARY) **Thrombosis of brain**
Nephritis (duration) yrs. mos. ds. **21**

18. WHERE WAS DISEASE CONTRACTED

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

20. WERE THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **H. Garrison**, M. D.

(Address) **Novinger 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

LOTZ CEMETERY

DATE OF BURIAL

9-14 1927

20. UNDERTAKER

Carroll Wilson
Keokuk

ADDRESS

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact amount of carefully supplied.

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; Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (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

36369

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

2 FULL NAME Albert Pruitt Suppl. 22. 1927
 (a) Residence. No. Nowinger 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 (write the word) M.

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

6 DATE OF BIRTH (month, day, and year) Jan 27 - 1861

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

66 7 13

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith
 (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) Mo.

10 NAME OF FATHER _____
 11 BIRTHPLACE OF FATHER (city or town) _____
 (State or country) Ky.
 12 MAIDEN NAME OF MOTHER _____
 13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country) _____

14 Informant _____
 (Address) _____

15 Filed _____, 19 _____

129B MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEP 12. 1927 19 _____

17 I HEREBY CERTIFY, That I attended deceased from
Aug 26, 1926, to Sept 12, 1927
 that I last saw him alive on Sept 12, 1927
 and that death occurred, on the date stated above, at 1205 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) 1 yrs. _____ mos. _____ ds.
 CONTRIBUTORY Prom basis of brain
(Secondary)
Myelitis (duration) _____ yrs. _____ mos. 31 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? none
 (Signed) A. G. Harrison, M. D.
 , 19 (Address) Nowinger Mo.

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

20 UNDERTAKER _____ ADDRESS _____

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.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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BY PHYSICIAN.

S-26369