

DEC 17 1937

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

41144

1. PLACE OF DEATH

County Dent
Township WAKEFORD
City WAKEFORD

Registration District No. 1625
Primary Registration District No. 5377

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Eliza Giles O'Boannon

(a) Residence No. _____ 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-21-1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 4 6

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

14. INFORMANT S. B. O'Boannon
(Address) Ironton

15. FILED 1-18-1936 J. A. Kussick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 27 1925

17. I HEREBY CERTIFY that I attended deceased from 11/21/1849 to 3/27/1925 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:

Boiler explosion

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 195
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) O. B. Mc Bride, M. D.
, 19____ (Address) Licking 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 Ironton Mo
DATE OF BURIAL 3/29 1925

20. UNDERTAKER Carl Spencer
ADDRESS Salmon 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*, *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*

"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 child-birth 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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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41144
Do not use this space.

1. PLACE OF DEATH

(a) County Dent Registration District No. 1035
(b) Township Current Primary Registration District No. 5391
(c) City..... (d) Street No..... St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No.

2. PRINT FULL NAME

Eliga Elias O'Bannon
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-21-1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 4 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. saw
9. Industry or business in which work was done, as saw mill, bank, etc. milling
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Mo

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) J B O'Bannon Dent Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Proton Mo DATE 5-29 1925

19. FUNERAL DIRECTOR (ADDRESS) Carl Spencer Salem Mo

20. FILED 1/18 1938 J A Kissack Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 27 1935

22. I HEREBY CERTIFY, That I attended deceased from Did not attend deceased

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Boiler Explosion

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) O. C. Mc Bride, M. D.

(Address) Kicking Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every member of the profession should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state

**MISSOURI STATE BOARD OF HEALTH
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For use in Missouri

1. PLACE OF DEATH

(a) County _____
 (b) Town ship _____
 (c) City _____
 (d) Birth place of decedent in city or town where death occurred _____
 (e) How long in Missouri _____
 (f) How long in this county _____

2. PRINT FULL NAME

(a) _____
 (b) _____
 (c) _____

PERSONAL AND STATISTICAL PARTICULARS

1. SEX	2. COLOR OR RACE	3. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
4. DATE OF BIRTH (MONTH, DAY, AND YEAR)	5. AGE	6. MARRIED, WIDOWED OR DIVORCED (a) HUSBAND OR (b) WIFE OF
7. OCCUPATION (month and year)	8. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE (as well, bank, etc.)	9. TRADE, PROFESSION OR PARTICULAR KIND OF OCCUPATION, EXERCISE OF, BOOKKEEPER, ETC.
10. DATE HE BECAME WORKER AS OCCUPATION (month and year)	11. Total time (years) spent in this occupation	12. DATE OF DEATH (MONTH, DAY, AND YEAR)
13. YEARS	14. MONTHS	15. DAYS
16. IF LESS THAN 1 day, hour or min.		

MEDICAL CERTIFICATE OF DEATH

1. I HEREBY CERTIFY, that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Births and Deaths, Missouri State Board of Health, at St. Louis, Missouri, on the _____ day of _____, 19____.

2. The principal cause of death and related causes of death are as follows: _____

3. Other contributory causes of importance: _____

4. Name of physician _____
 What part of patient's history _____
 Date of signature _____

5. If death was due to external cause (e.g., fire, lightning, accident, etc.), state the nature and extent of the injury: _____
 Where the injury occurred _____
 Specify whether injury occurred in industry, in home, or in public place _____
 Name of industry _____
 Nature of injury _____
 Date of injury _____

6. Was disease or injury in any way related to occupation of decedent? _____
 If so, specify _____
 (Signed) _____
 M. D.

17. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

18. NAME _____

19. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

20. MAIDEN NAME _____

21. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

22. INFORMANT (ADDRESS) _____

23. BURIAL CREMATION OR REMOVAL _____

24. PLACE _____

25. FUNERAL DIRECTOR (ADDRESS) _____

26. FILED _____

Local Registrar _____

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 ST. LOUIS, MISSOURI