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

9534

1 PLACE OF DEATH

County Knox

Township Colony — Registration District No. 1056 — File No. 45

or Village — Primary Registration District No. 5594 — Registered No. 45

or City .... (NO. .... St.; .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Isaac Benton Carney

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Male — 4 COLOR OR RACE: White — 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	16 DATE OF DEATH: March (Month) 16 (Day), 1918 (Year)
6 DATE OF BIRTH: April (Month) 16th (Day), 1839 (Year)	17 I HEREBY CERTIFY, that I attended deceased from Sept 1, 1918, to March 16, 1918, that I last saw him alive on on March 10, 1918, and that death occurred, on the date stated above, at 7 a.m.
7 AGE: 78 yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?	The CAUSE OF DEATH* was as follows: Abcess of Frontal Sinus 47C 104D (Duration) ..... yrs. 2 mos. ..... ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farmer. (b) General nature of industry, business or establishment in which employed (or employer): same	CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.
9 BIRTHPLACE (City or town, State or foreign country): Mo	(Signed) J R Northcutt M. D. March 17, 1918 (Address) Knox City Mo.
PARENTS — 10 NAME OF FATHER: Alexander Carney	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
12 MAIDEN NAME OF MOTHER: Do not Know	At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia	Where was disease contracted if not at place of death? ..... Former or usual residence .....
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) G S Carney (Address) Knox City Mo.	19 PLACE OF BURIAL OR REMOVAL: Colony — DATE OF BURIAL: Mar 17, 1918
15 Filed March 16, 1918 C E Hoffman, Registrar	20 UNDERTAKER: J O Crowley — ADDRESS: Rutledge 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, peritonaeum*, 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,*" "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "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.)

PLACE OF DEATH

County Knox

Township Coloney

or

Village

or

City (NO. St.; Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 1056

Primary Registration District No. 5597

File No.

Registered No. 45

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

FULL NAME Grace Burton Comey

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) W

DATE OF BIRTH ..... 1 (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)

PARENTS

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 March 16, 1918 C E Hoffman REGISTRAR

Original file, date ..... 19....

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 16, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191...,

that I last saw h... alive on ....., 191...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Abscess of frontal sinus

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory Carcinoma of rectum
(SECONDARY)

(Duration) 1 yrs. 6 mos. ..... ds.

(Signed) J R Woodcock M. D.

March 19, 1918 (Address) Army City Ind

*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

DATE OF BURIAL ....., 191...

UNDERTAKER J R Comley

ADDRESS Rushville Ind

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]

95234

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