

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.

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

PLACE OF DEATH
 County Jasper
 Township Joplin
 or
 Village Walt City
 or
 City Walt City (NO. 416 97 John St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
 Registration District No. 417 File No. 639
 Primary Registration District No. 3021 Registered No. 13
 FULL NAME Frank Bernhardt

PERSONAL AND STATISTICAL PARTICULARS	
SEX <u>Male</u>	COLOUR OR RACE <u>Amur</u>
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)	
AGE <u>32</u> yrs. mos. ds.	If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Drug Clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Drug Store</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Unknown</u>	
PARENTS	NAME OF FATHER <u>Unknown</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>
	MAIDEN NAME OF MOTHER <u>Unknown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>O. S. Sney</u> (ADDRESS) <u>Walt City Mo</u>	
Filed _____ 191_____	REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Jan 17</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Jan 17, 1910</u> , to <u>Jan 17, 1910</u> , that I last saw him alive on <u>Jan 17, 1910</u> , and that death occurred, on the date stated above, at <u>2 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> <u>Cerebral Hemorrhage</u> <u>82 A</u>	
(Duration) yrs. mos. ds.	
Contributory (SECONDARY) <u>Unknown</u> (Duration) yrs. mos. ds.	
(Signed) <u>O. S. Sney</u> M. D. (Address) <u>Walt City</u>	
*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. <u>2</u> yrs. <u>2</u> mos. ds. In the <u>32</u> yrs. mos. ds. State	
Where was disease contracted if not at place of death? Former or usual residence <u>Butler Mo</u>	
PLACE OF BURIAL OR REMOVAL <u>Butler Mo</u>	DATE OF BURIAL <u>Jan 19, 1910</u>
UNDERTAKER <u>Walt City Undertaking Co</u>	ADDRESS <u>Walt City Mo</u>

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, meningis, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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 *septicaemia*," "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.)



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.

PLACE OF DEATH

County Jasper
 Township _____
 or _____
 Village _____
 or _____
 City Webb City (NO. 416 W. John St.; _____ Ward)

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

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

Registration District No. 417 File No. 639
 Primary Registration District No. 3021 Registered No. 3

FULL NAME

Frank Bernhardt

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M.</u>	COLOR OR RACE <u>Am.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>unknown</u> (Month) (Day) (Year)		
AGE <u>32</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Drug Clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Drug Store</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Unknown</u>		
PARENTS	NAME OF FATHER <u>Unknown</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	
	MAIDEN NAME OF MOTHER <u>Unknown</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 17, 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 17, 1910, to Jan. 17, 1910, that I last saw alive on Jan. 17, 1910, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
Arterial hemorrhages

(Duration) _____ yrs. _____ mos. 1/2 ds.

Contributory unknown
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. S. Hufley M. D.
 _____ 1910 (Address) Webb City

*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. 2 ds. In the 32 yrs. _____ mos. _____ ds. State 32 yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
 Former or usual residence Butler, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) A. S. Hufley
 (ADDRESS) Webb City, Mo.

PLACE OF BURIAL OR REMOVAL Butler, Mo. DATE OF BURIAL Jan. 19, 1910
 UNDERTAKER Webb City, Mo. ADDRESS Webb City, Mo.

Filed Mar 14, 1910 E. H. Baird REGISTRAR

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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