

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

PLACE OF DEATH

County Livingston  
Township Sampson  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

12  
Registration District No. 508 File No. 2318  
Primary Registration District No. 5676 Registered No. 13

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

FULL NAME Marcus Gaine

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married  
(If less than 1 day, \_\_\_ hrs. or \_\_\_ min.?)  
DATE OF BIRTH Jan 7 1846  
(Month) (Day) (Year)  
AGE 65 yrs. 17 mos. 17 ds.  
OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

DATE OF DEATH Jan 24 1911  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from Jan 10, 1910., to Jan 24, 1911., that I last saw him alive on Jan 22, 1911., and that death occurred, on the date stated above, at 10 a.m.  
The CAUSE OF DEATH\* was as follows:  
Bright's disease  
(Chronic)  
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BIRTHPLACE (City or town, State or foreign country) Livingston Co Mo  
NAME OF FATHER Nathan Gaine  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Idaho  
MAIDEN NAME OF MOTHER Sanna B. Frozier  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

(Duration) 2 yrs. 0 mos. 17 ds.  
Contributory Sampson  
(SECONDARY) (Duration) 20 yrs. 0 mos. 17 ds.  
(Signed) A. Y. Minsick M. D.  
Jan 24 1911 (Address) Roll Spring Mo  
\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) David Gaine  
(ADDRESS) Sampson

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death 2 yrs. 0 mos. 17 ds. In the State 65 yrs. 0 mos. 17 ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence 2

Filed Jan 28 1911 R. Barney  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Boucher Ametry DATE OF BURIAL Jan 26 1911  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_ (NO \_\_\_\_\_)

File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

Ward \_\_\_\_\_

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

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_

COLOR OR RACE \_\_\_\_\_

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(If file the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

IF LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

OCCUPATION \_\_\_\_\_

(a) Trade, profession, or business, or establishment in which employed (or employer)

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE \_\_\_\_\_ (City or town, State or foreign country)

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 \_\_\_\_\_ 191\_\_\_\_\_

REGISTRAR

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

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ (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:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory

(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_

191\_\_\_\_\_ (Address) \_\_\_\_\_

M. \_\_\_\_\_

\*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 \_\_\_\_\_

ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH  
 County Linn  
 Township Sampsell  
 or  
 Village  
 or  
 City

Registration District No. 508 File No. 7318  
 Primary Registration District No. 5676 Registered No.  
 (No. \_\_\_\_\_) St.: \_\_\_\_\_ Ward)

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

FULL NAME Enanias G. Gawn

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED married  
 (Write the word)  
 DATE OF BIRTH 1-7- 1846  
 (Month) (Day) (Year)  
 AGE 65 yrs. 17 mos. 17 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) "

BIRTHPLACE  
 (City or town, State or foreign country) Linn Co. Mo.

NAME OF FATHER Nathan Gawn

BIRTHPLACE OF FATHER  
 (City or town, State or foreign country) Mo.

MAIDEN NAME OF MOTHER Serenity Boyer

BIRTHPLACE OF MOTHER  
 (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 Informant) David Gawn

(ADDRESS) Sampsell.

Filed Jan 28 1911 R Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_, 1911  
 (Month) 1-24 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-10, 1911, to 1-24, 1911, that I last saw him alive on 1-22, 1911, and that death occurred, on the date stated above, at 10 m. The CAUSE OF DEATH\* was as follows:

Bright's Disease (Chronic)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory: Dyspepsia  
 (SECONDARY) (Duration) 20 yrs. 0 mos. 17 ds.

(Signed) A. G. Meyrick M. D.  
1-24, 1911 (Address) Local Spg

\*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 Baucher Cem. DATE OF BURIAL 1-26-, 1911

UNDERTAKER Mohr & Sons ADDRESS Bellevue

# 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, 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.)