

PLACE OF DEATH

County Ray

Township _____

or

Village _____

or

City Richmond (NO. _____)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 744File No. 42448Primary Registration District No. 3035Registered No. 98

St.: _____ Ward _____

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

FULL NAME Richard Workman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

Black

SINGLE

MARRIED

OR WIDOWED

OR DIVORCED

(Write the word)

married

DATE OF BIRTH

Oct 71865

(Month)

(Day)

(Year)

AGE

46 yrs. 1 mos. 20 ds.

If LESS than

1 day, _____ hrs.

or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Miner

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

Miner

BIRTHPLACE

(City or town, State or foreign country)

Adair Co Ky

NAME OF FATHER

William Workman

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ky

MAIDEN NAME OF MOTHER

Don't know

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Jones

(ADDRESS)

Richmond

Filed

Dec 28

1911

J. M. H. H. H.
Deputy

REGISTRAR

DATE OF DEATH

12/27/1911

(Month)

(Day)

1911
(Year)

I HEREBY CERTIFY, that I attended deceased from

Dec 25, 1911, to Dec 27, 1911,that I last saw him alive on Dec 25, 1911,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contagious

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. T. W. Wright M. D.12-28 1911 (Address) Richmond

* 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

City Cemetery

DATE OF BURIAL

Dec 28, 1911

UNDERTAKER

W. H. H. H.

ADDRESS

Richmond

210

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.

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.)



PLACE OF DEATH
 County Ray
 Township _____
 or
 Village _____
 or
 City Richmond (NO. _____ St.: _____ Ward _____)

Registration District No. 744 File No. _____
 Primary Registration District No. 3035 Registered No. 98

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

FULL NAME Richard Workman

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE Black SINGLE MARRIED married
 WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Oct 7, 1865
 (Month) (Day) (Year)

AGE 46 yrs. 1 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.

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

BIRTHPLACE (City or town, State or foreign country) Adair Co. Ky.

NAME OF FATHER William Workman

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

MAIDEN NAME OF MOTHER Don't know.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Jones
 (ADDRESS) Richmond, Mo.

Filed Feb 24 1912 Geo H Hunt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12/27, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 20, 1911, to Dec. 27, 1911, that I last saw him alive on Dec. 20, 1911, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lobar-Pneumonia*

(Duration) ___ yrs. ___ mos. 8 ds.

Contributory none
 (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) _____ M. D.
12-28 1911 (Address) Richmond

*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 City Cemetery DATE OF BURIAL Dec 28 1911

UNDERTAKER Stennett ADDRESS Richmond Mo.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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