

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Buchanan
Township Platte Registration District No. 80 File No. 186
or
Village _____ Primary Registration District No. 5721 Registered No. 1
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Bert Harvey Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH July 27, 1882
(Month) (Day) (Year)
AGE 29 yrs. 6 mos. 6 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE
(City or town, State or foreign country) mo 1-02

PARENTS
NAME OF FATHER William Barnes
BIRTHPLACE OF FATHER (City or town, State or foreign country) mo
MAIDEN NAME OF MOTHER Mandy Gidding
BIRTHPLACE OF MOTHER (City or town, State or foreign country) mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Barnes
(ADDRESS) Fragier mo

Filed Jan 27, 1912 R. F. Donnell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 26, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Jan 20, 1912, to Jan 26, 1912, that I last saw him alive on Jan 26, 1912, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:
Pneumonia fever
108
6 (Duration) yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) J. D. Reynolds M. D.
Jan 30, 1912 (Address) Gower mo

*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 Hebron cemetery DATE OF BURIAL Jan 27, 1912
UNDERTAKER Lucian Davis ADDRESS Edgerton mo

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

(NO. _____)

Registration District No. _____

File 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
(Write the word)

DATE OF BIRTH _____

AGE _____

(Month) _____ (Day) _____ (Year) _____

IF LESS than
1 day, _____ hrs.
or _____ min.?

_____ yrs. _____ mos. _____ ds.

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)

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____, 191_____ (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) _____

(Address) _____

M. D. _____

*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. 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 _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

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

CERTIFICATE OF DEATH

County Buchanan Registration District No. 80 File No. 186
 Township Platte Primary Registration District No. 5121 Registered No. 1
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

FULL NAME Bert Harvey Barnes

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)	DATE OF DEATH <u>Jan 26</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>July 27</u> , 188 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan 20</u> , 191 <u>2</u> , to <u>Jan 26</u> , 191 <u>2</u> , that I last saw <u>alive</u> on <u>Jan 26</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>7 P.</u> m.	
AGE <u>29</u> yrs. <u>6</u> mos. <u>ds.</u>			The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>William Barnes</u>		(Signed) <u>J. D. Reynolds</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>		<u>Jan 27</u> 191 <u>2</u> (Address) <u>Tower</u>	
	MAIDEN NAME OF MOTHER <u>Mandy Giddings</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>William Barnes</u>			Where was disease contracted if not at place of death? _____ Former or usual residence _____	
(ADDRESS) <u>Frazier Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Hebron Mo</u>	
Filed <u>1/27</u> 19 <u>12</u> <u>R. F. Doval</u> REGISTRAR			DATE OF BURIAL <u>Jan 27</u> , 191 <u>2</u>	
			UNDERTAKER <u>Lucien Davis</u>	
			ADDRESS <u>Edgerton Mo</u>	

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

JAN

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* (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.)