

MARGIN RESERVED FOR BINDING

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 Dunklin
Township _____ Registration District No. 282 File No. 4742
or Village _____ Primary Registration District No. 4166 Registered No. 10
or City Campbell (NO. _____ St. _____ Ward _____)
FULL NAME Mike Gromes [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single
MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH July 21, 1850
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. _____ mos. _____ ds.

OCCUPATION
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) - 0 - 0

BIRTHPLACE
(City or town, State or foreign country) Campbell Mo

PARENTS

NAME OF FATHER Gromes
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know
MAIDEN NAME OF MOTHER Dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jake Gromes
(ADDRESS) Campbell Mo
Filed 7/17 1912 6.21.1912 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 14, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 3d, 1912, to July 14, 1912, that I last saw him alive on July 11th, 1912, and that death occurred, on the date stated above, at 10:40 P.M.
The CAUSE OF DEATH* was as follows:
Renal Debility
Paralysis
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) Paralysis
(Duration) 43 yrs. _____ mos. _____ ds.
(Signed) G. W. Brown M. D.
7/17, 1912 (Address) Campbell 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 Elder Cem DATE OF BURIAL 7/15, 1912
UNDERTAKER O. McBride ADDRESS Campbell 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*, *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 DunklinREGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

Township _____

Registration District No. 282File No. 4742or
Village _____Primary Registration District No. 4166Registered No. 10or
City Campbell (NO. _____)

St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE S
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH Feb 24, 1912
(Month) (Day) (Year)AGE 6 yrs. 11 mos. 29 ds. If LESS than
1 day, _____ hrs. _____ min.OCCUPATION
(a) Trade, profession, or
particular kind of work none
(b) General nature of industry,
business, or establishment in
which employed (or employer) _____BIRTHPLACE
(City or town, State or foreign country) Campbell MoPARENTS NAME OF FATHER JamesBIRTHPLACE OF FATHER (City or town, State or foreign country) MoMAIDEN NAME OF MOTHER MoBIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike James(ADDRESS) Campbell MoFile 717 1912 W. B. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 14, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
Jan 3, 1912, to Feb 14, 1912,
that I last saw him alive on Jan 11, 1912,
and that death occurred, on the date stated above, at 10:10 p. m.The CAUSE OF DEATH* was as follows:
Senile Debility

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

Contributory Paralysis
(SECONDARY) (Duration) 43 yrs. _____ mos. _____ ds.(Signed) W. B. Brown M. D.
W. B. Brown 1912 (Address) Campbell 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 Elder Cemetery DATE OF BURIAL 4/15, 1912UNDERTAKER C. M. Brude ADDRESS Campbell Mo

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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.)