

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 Texas
Township _____
or _____
Village _____
or _____
City Cabool (NO. _____)

Registration District No. 862 File No. 55-2896
Primary Registration District No. 4521 Registered No. 2
St. _____ Ward _____

FULL NAME Geo Otto Cunningham [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 w. SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH Oct 20 1912
(Month) (Day) (Year)

AGE 2 yrs. 2 mos. 28 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 0

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

NAME OF FATHER Austin Cunningham

BIRTHPLACE OF FATHER (City or town, State or foreign country) Texas Co

MAIDEN NAME OF MOTHER Rachel Llewark

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Austin Cunningham
(ADDRESS) Cabool Mo

Filed Jan 18 1913. J. J. Robertson
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 18 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 20 1912 to Jan 18 1913, that I last saw him alive on Jan 18 1913, and that death occurred on the date stated above, at 12:25 a.m.

The CAUSE OF DEATH* was as follows:
Starvation
1180
158 ✓
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary) J. W. Patterson
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. W. Patterson M. D.
Jan 18 1913 (Address) Cabool 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 Cabool Emly DATE OF BURIAL Jan 18 1913

UNDERTAKER W. R. Clifton ADDRESS Cabool Mo

[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*, *Sarcoma*, 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.)

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

PLACE OF DEATH

County Texas

Township _____

or Village _____

or City Cabool (NO. _____)

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

BUREAU OF VITAL STATISTICS
STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Registration District No. 862

File No. 35

Primary Registration District No. 4521

Registered No. 2

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

FULL NAME Geo. Otto Cunningham

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Oct. 20</u> , 191 <u>2</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>28</u> mos. <u>28</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS	NAME OF FATHER <u>Austin Cunningham</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Texas Co.</u>
	MAIDEN NAME OF MOTHER <u>Rachel Newark</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Van Buren Ill.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Austin Cunningham
(ADDRESS) Cabool, Mo.

Filed Jan 18, 1913, J. F. Robertson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan. 18, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 20, 1912 to Jan. 18, 1913, that I last saw him live on Jan. 18, 1913, and that death occurred, on the date stated above, at 12.28 m.

The CAUSE OF DEATH* was as follows:
Indigestion & General Mal-nutrition.
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory
(SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. W. Patton, M.D.
Jan. 18, 1913 (Address) Cabool, 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 <u>Cabool Cem.</u>	DATE OF BURIAL <u>Jan. 18</u> , 191 <u>3</u>
UNDERTAKER <u>W. R. Clifton</u>	ADDRESS <u>Cabool, Mo.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY IN PLAIN TERMS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated in plain terms. If death occurred in a hospital or institution, give its NAME instead of street and number.

Revised United States Standard Certificate of Death

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

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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, Sarcoma*, 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 "*Asithenia*," "*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.)

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