

WHILE 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 Missouri
 Township St. James Registration District No. 567 File No. 9966
 or _____
 Village _____ Primary Registration District No. 5763 Registered No. 20
 or _____
 City _____ (NO. _____ St.; _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Robert P. Easter

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Child</u>
DATE OF BIRTH <u>Jan - 11 - 1913</u> (Month) (Day) (Year)		
AGE <u>7</u> yrs. <u>6</u> mos. <u>6</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) <u>— 0 - 0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Amurston</u>		
PARENTS	NAME OF FATHER <u>Tom Easter</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St. James Mo</u>	
	MAIDEN NAME OF MOTHER <u>Sattie Trubbs</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Livingston N.C.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>[Signature]</u> (ADDRESS) <u>Amurston</u>		
Filed <u>Mar 5</u> 191 <u>3</u> <u>J. S. Davis</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 18, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1913, to Feb 18, 1913
 that I last saw him alive on Feb 17, 1913
 and that death occurred, on the date stated above, at 9A m.
 The CAUSE OF DEATH* was as follows:
Labourer
107A Pneumonia
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. L. Frasier M. D.
Feb - 18, 1913 (Address) Amurston

*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 Lake Grove DATE OF BURIAL Feb 19, 1913
 UNDERTAKER J. S. White & Co. ADDRESS Amurston 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, peritonaeum*, 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.)

PLACE OF DEATH

County

Township

or Village

or City

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

Registration District No.

Primary Registration District No.

(NO.

St.

Ward)

File No.

Registered No.

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

FULL NAME

Robert L. Easter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Child

DATE OF DEATH

2 - 18, 1913 (Month) (Day) (Year)

DATE OF BIRTH

June 11, 1913 (Month) (Day) (Year)

AGE

If LESS than 1 day, hrs. or min. 2 yrs. mos. ds.

I HEREBY CERTIFY, that I attended deceased from Feb 11, 1913, to Feb 18, 1913, and that death occurred, on the date stated above, at 9 m. Satisfactory information supplied.

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

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

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

BIRTHPLACE

(City or town, State or foreign country)

Armistonia, Mo.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

PARENTS

NAME OF FATHER

Tom Easter

BIRTHPLACE OF FATHER

James, Mo.

MAIDEN NAME OF MOTHER

Sally Grubbs

BIRTHPLACE OF MOTHER

Livingston, N.C.

(Duration) yrs. mos. ds.

(Signed) T. L. Culey, M. D.

Feb 18, 1913 (Address) Armistonia, 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tom Easter

(ADDRESS)

Armistonia, Mo.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At Satisfactory information supplied

Feb 19, 1913

UNDERTAKER

ADDRESS

J. S. White & Co

Armistonia, Mo.

Filed

3-5 1913

J. S. Reiss

REGISTRAR

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

Revised United States Standard Certificate of Death

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

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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.)