

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 Buffalo
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 283 File No. 29466
Primary Registration District No. 5402 Registered No. 250

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

FULL NAME McCoy Rinehart

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF FACE White SINGLE MARRIED WIDOWED OR DIVORCED Infant
(Write the word)

DATE OF BIRTH Jan 22nd 1913
(Month) (Day) (Year)

AGE 7 yrs 7 mos 16 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) _____

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

PARENTS
NAME OF FATHER Cal. Rinehart
BIRTHPLACE OF FATHER (City or town, State or foreign country) Clay Co. Ark
MAIDEN NAME OF MOTHER Willa Ware
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stoddard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Rinehart
(ADDRESS) Baynton Ave

Filed Sept 5th 1913 Eli Baese REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 5th 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug-15, 1913, to Sept-4th, 1913; that I last saw him alive on Sept-4th, 1913, and that death occurred, on the date stated above, at 1-9 a.m.

The CAUSE OF DEATH* was as follows:
Ganglion Sacch. & Bours.
119B
118C
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Dr. Hubbard M. D.
Sept 5, 1913 (Address) Baynton Ave

*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 Senath Mo DATE OF BURIAL Sept 6th 1913
UNDERTAKER James M Anderson ADDRESS Cardwell 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*, *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 septicæmia," "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

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

PLAQUE OF DEATH
County Dunklin
Township Buffalo
Village _____
City _____

Registration District No. 283 File No. _____
Primary Registration District No. 5402 Registered No. 250

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

FULL NAME McBay Rinehart (NO. _____ St. _____ Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m. COLOR OR RACE w. SINGLE s. MARRIED _____ WIDOWED _____ OR DIVORCED _____
(Write the word)

DATE OF DEATH Sept. 5, 1913
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (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.

AGE _____ yrs. _____ mos. _____ ds. IF LESS than _____ day, _____ hrs. _____ or _____ min.

Satisfactory Information Supplied. 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) _____

CAUSE OF DEATH* was as follows: Congestion Stomach & bowels (Emericis)

BIRTHPLACE (City or town, State or foreign country) _____

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

PARENTS 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) _____

(Signed) W. H. Hubbard M. D. Sept 5, 1913 (Address) Waynton Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory Information Supplied.

*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 _____

(ADDRESS) _____ Filed Sept 5, 1913 Eli Beck REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____ ADDRESS _____ UNDERTAKER Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

09162

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