

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

15-3

PLACE OF DEATH

County Greene

Township _____

Registration District No. 318

File No. 4524

Village _____

Primary Registration District No. 2001

Registered No. 67

City Springfield (NO. 2nd & Hillhouse 8 Ward)

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

FULL NAME Luckens Braswell

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>
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DATE OF BIRTH Nov 30, 1897
(Month) (Day) (Year)

AGE 16 yrs. 3 mos. 7 ds.
if LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS	NAME OF FATHER <u>C Braswell</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Greene Mo</u>
	MAIDEN NAME OF MOTHER <u>Cain</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Wasson Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L Braswell

(ADDRESS) Springfield Mo

Filed Feb 7, 1914 by D. C. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 7, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 3rd, 1914, to Feb 7, 1914, that I last saw her alive on Feb 6, 1914, and that death occurred, on the date stated above, at 6³⁵ a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia (Labor)

Contributor Measles
(Duration) ___ yrs. ___ mos. 2 ds.

(Signed) B. F. Freeman, Jr., M. D.
Feb 7, 1914 (Address) Springfield 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 Liberty Church DATE OF BURIAL Feb 7, 1914

UNDERTAKER W. J. Major ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of Missouri, U.S.S. & C. 1912, Revised.

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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County

Green

Township

Registration District No.

318

File No.

or Village

Primary Registration District No.

2001

Registered No.

*67*City *Springfield* (NO *St. Louis & Keokuk* St. *8* Ward)

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

FULL NAME

Loekie Braswell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

M

COLOR OR RACE

w

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

S

DATE OF DEATH

(Month)

(Day)

191*4*
(Year)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

IF LESS than
1 day, ___ hrs
or ___ min
___ yrs. ___ mos. ___ ds.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 *6:50 am*.
The CAUSE OF DEATH* was as follows:

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

Angela Cain

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

3/7

191

W. W. Smith
REGISTRAR

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

191____ (Address)

*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

DATE OF BURIAL

191____

UNDERTAKER

ADDRESS

Original file, date

191

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

EXACTLY. PHYSICIANS should state important.

Revised United States Standard Certificate of Death

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

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