

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 Wright Co
Township Wood
or St. Louis
Village St. Louis
or
City _____ (NO. _____) _____ (St. _____) _____ (Ward _____)

V908
Registration District No. _____ File No. _____
6223
Primary Registration District No. _____ Registered No. 17
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Robert T. Rowley

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) W

DATE OF BIRTH Robt T Rowley, 1888
Don't know (Month) etc (Day) (Year)

AGE 76 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) N.Y.

PARENTS
NAME OF FATHER unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mass
MAIDEN NAME OF MOTHER unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J J Pastor
(ADDRESS) _____

Filed Mar 28 1914. E. J. Butke REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 27, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 26, 1914, to Mar 27, 1914, that I last saw him alive on Mar 26, 1914, and that death occurred, on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH* was as follows:
Parasitic Agitation

11 P
87 A
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) J. R. Talley M. D.
Mar 28, 1914. (Address) Mountain Grove 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 Plumtree View DATE OF BURIAL March 28, 1914

UNDERTAKER W. W. Izard ADDRESS Miss Groul

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

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

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

County Wright
Township Wood
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 908 File No. _____
Primary Registration District No. 6223 Registered No. 17

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

FULL NAME Robert F. Rawley

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word) <u>88</u>
DATE OF BIRTH _____, _____, 191 <u>4</u> (Month) (Day) (Year)		AGE _____, _____, _____ yrs. mos. ds.
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		IF LESS than 1 day, _____ hrs. _____ min. or _____ min.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 27, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, to _____, 1914, that I last saw h_____ alive on _____, 1914, and that death occurred, on the _____ stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows _____

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)

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

(Signed) _____ M. D. _____ 1914 (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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Danton
(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

UNDERTAKER _____ ADDRESS _____

Filed 3/28 1914 E. J. Butzke REGISTRAR

Original file, date 3-1914 All information called for must be written on this Supplementary Certificate.

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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11488

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