

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

PLACE OF DEATH

County Montgomery
Township Pratville
or
Village Middleton
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 591
Primary Registration District No. 5789

File No. 23388
Registered No. 11

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

FULL NAME Francis M. Bourne

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>July</u> (Month) <u>3rd</u> (Day) <u>1856</u> (Year)		
AGE <u>56</u> yrs. <u>11</u> mos. <u>27</u> ds. <small>If LESS than 1 day, ____ hrs. or ____ min.?</small>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> <u>U.S.D.</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Middletown, Mo.</u>		
PARENTS	NAME OF FATHER <u>Leaniel Bourne</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>N.Y.</u>	
	MAIDEN NAME OF MOTHER <u>Susan Hill</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>N.Y.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 29 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb, 1914, to June 29, 1914, that I last saw him alive on 29 June, 1914, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Myocardial Break down
from the results of
Cancer

(Duration) 3 yrs. 5 mos. 5 ds.

Contributory neglect U.S.
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Chas. O. Ogden, M. D.
July 3rd 1914 (Address Wardensburg 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) Gra Bourne
(ADDRESS) Middletown, Mo.

PLACE OF BURIAL OR REMOVAL Middletown Mo. DATE OF BURIAL June 30, 1914

UNDERTAKER J. J. Jones ADDRESS Middletown, Mo.

Filed July 5, 1914 J. H. Ford REGISTRAR

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.

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*, *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.)

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

PLACE OF DEATH
County Montgomery
Township Prairie
or
Village
or
City

Registration District No. 591 File No.
Primary Registration District No. 5787 Registered No. 11
(NO. St. Ward)

FULL NAME Francis M. Bourne

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE A. SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH June 29, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
_____, 191____, to _____, 191____,
that I last saw him on _____, 191____,

AGE _____
yrs. mos. ds. If LESS than
_____, hrs. min. sec.

and that death occurred, on the date stated above, at _____ m.

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:
Gen. Break Down from
the results of cancer of
Superior Maxilla.

BIRTHPLACE
(City or town, State or foreign country)

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

NAME OF FATHER

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

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

(Signed) Chas. O. Ozias M.D.
July 3, 1914 (Address) Harrodsburg Mo

MAIDEN NAME OF MOTHER

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)

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

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 _____

FILED _____ 191____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

REGISTRAR Geo. Ford

UNDERTAKER _____ ADDRESS _____

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SUPPLEMENTARY
Satisfactory Information Supplied.

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Satisfactory Information Supplied.

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