

PLACE OF DEATH

County Newton

Township _____

or

Village _____

or

City Neosho (NO. _____)Registration District No. 609File No. 26809Primary Registration District No. 4362

Registered No. _____

St. _____ Ward _____

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

FULL NAME: Luther H. Cunningham

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH July 24 (Month) (Day) (Year)AGE 65 yrs. 10 mos. 19 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Loc Stock Cpt. R.R.

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

BIRTHPLACE

(City or town, State or foreign country) Columbia Mo.PARENTS NAME OF FATHER Henry CunninghamBIRTHPLACE OF FATHER (City or town, State or foreign country) N.Y.MAIDEN NAME OF MOTHER Dorothy BentleyBIRTHPLACE OF MOTHER (City or town, State or foreign country) N.Y.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed Aug 6 1914 W. D. Roseberry REGISTRARMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2) MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 5 (Month) (Day) (Year) 1914

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. and alive on Aug 5, 1914,

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

The CAUSE OF DEATH* was as follows:

Head on Rail Way Collision
possibly burnif. to death70 P.M.
70 P.M. (Duration) 175 yrs. mos. ds.

Contributory (SECONDARY) _____

(Duration) _____ yrs. mos. ds.

(Signed) J. J. Bigham Cooper
Aug 7 1914 (Address) Neosho 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 _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL L.O.P. Plum DATE OF BURIAL _____ 1914UNDERTAKER F. J. Bigham Co. ADDRESS Neosho Mo.

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 in very important.

STATE OF MISSOURI—THIS IS A PERMANENT RECORD

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, 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.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL 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

County Newton Registration District No. 609 File No. _____
 Township _____ or Village Neosho Primary Registration District No. 4363 Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____

FULL NAME Luther A. Orumbough

(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 <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> <small>(Write the word)</small>	DATE OF DEATH <u>July 5</u> , 19 <u>14</u> <small>(Month) (Day) (Year)</small>		
DATE OF BIRTH _____ <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from _____, 19 <u>14</u> , to _____, 19 <u>14</u> , that I last saw h_____ alive on _____, 19 <u>14</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____		
AGE _____ yrs. _____ mos. _____ ds. <small>If LESS than 1 day, _____ hrs. or _____ min.</small>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.		
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) _____			(Duration) _____ yrs. _____ mos. _____ ds. Contributory (SECONDARY) _____ (Duration) _____ mos. _____ ds. (Signed) _____ M. D. _____, 19 <u>14</u> (Address) _____		
PARENTS	NAME OF FATHER _____		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 _____		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____				
	MAIDEN NAME OF MOTHER _____				
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 19 <u>14</u> UNDERTAKER _____ ADDRESS _____		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs J. H. Orumbough</u> (ADDRESS) <u>Neosho Mo</u> Filed <u>Aug 6</u> 19 <u>14</u> at <u>Ed. Roseberry</u> REGISTRAR					

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

Revised United States Standard Certificate of Death

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

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