

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

PLACE OF DEATH

County

*Callaway*

Township

or

Village

or

City

*Fulton* (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No.

*104*

File No.

*7650*

Primary Registration District No.

*3008*

Registered No.

*32*

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

FULL NAME

*Orvid Carter Collett*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

*3*

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

*male*

*white*

*Married*

DATE OF DEATH

*March*

*2nd*

1915

(Month)

(Day)

(Year)

DATE OF BIRTH

*Jun 2*

1866

(Month)

(Day)

(Year)

AGE

*48* yrs. *8* mos. *ds.*

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.?

I HEREBY CERTIFY, that I attended deceased from  
*January 8, 1915, to March 1st, 1915,*

that I last saw *him* alive on *March 1st, 1915,*

and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Accidental fall with  
injury to the spinal column*

OCCUPATION  
(a) Trade, profession, or particular kind of work

*Merchaut*

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

*Greer Salesman*

BIRTHPLACE

(City or town, State or foreign country)

*New Market Mo*

*1913* (Duration) *about 2* yrs. *2* mos. *ds.*

Contributory

(SECONDARY)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

PARENTS

NAME OF FATHER

*C W Collett*

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

*West & A*

MAIDEN NAME OF MOTHER

*A di Mays*

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

*Virginia*

(Signed) *W. H. Jones* M. D.

*March 2, 1915* (Address) *Fulton 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. 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)

*Miss Olive Collett*

(ADDRESS)

*Fulton Mo*

PLACE OF BURIAL OR REMOVAL

*Fulton Mo*

DATE OF BURIAL

*March 3, 1915*

UNDERTAKER

*J. A. Fulton*

ADDRESS

*Fulton Mo*

Filed

*3-2-*

*W. H. Jones*

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. A.R.C. should be stated EXACTLY. PHYSICIAN'S SIGNATURE

# 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.)

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

CERTIFICATE OF DEATH

PLACE OF DEATH  
County Callaway  
Township \_\_\_\_\_  
or  
Village Fulton  
or  
City Fulton (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 104 File No. \_\_\_\_\_  
Primary Registration District No. 3008 Registered No. 37

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

FULL NAME Orin C. Caples Callitt

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year)

AGE \_\_\_\_\_  
If LESS than 1 day, \_\_\_\_\_ hrs or \_\_\_\_\_ mins

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) \_\_\_\_\_

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) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/2/1915  
(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.

The CAUSE OF DEATH\* was as follows:  
Accidental fall with injury to the spinal column  
Paralysis (Pupaphoria)  
Roof of building collapsed with  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
(SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
3/2/1915 (Address) Fulton Mo.

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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 \_\_\_\_\_

SUPPLEMENTARY INFORMATION SUPPLIED

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