

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

PLACE OF DEATH

County Dunklin

Township Clay

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District 287

Primary Registration District No. 5405A

File No. 6009

Registered No. 5

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

FULL NAME Thomas L. Frost

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married  
(If wife the word)

DATE OF BIRTH 1 9 1858  
(Month) (Day) (Year)

AGE 58 yrs. 1 mos. 6 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

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

BIRTHPLACE (City or town, State or foreign country) Kentucky

NAME OF FATHER James Frost

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

MAIDEN NAME OF MOTHER Margret Hendrix

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.F. Krapf  
(ADDRESS) Hornersville Mo.

Filed 2-16 1916 T.F. Kinsolving REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 15 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12/25, 1915, to 2/12, 1916 that I last saw him live on 2/12, 1916, and that death occurred, on the date stated above, at 9.45 am

The CAUSE OF DEATH was as follows:  
Typhoid & malarial fever

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

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

(Signed) W.H. Baybaugh M.D.  
2/15, 1916 (Address) Hornersville 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 Hornersville Mo DATE OF BURIAL 2/16, 1916

UNDERTAKER T.F. Kinsolving ADDRESS Hornersville 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 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, 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.)

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

1 PLACE OF DEATH  
 County Dunklin  
 Township Clay  
 Village  
 City

Registration District No. 287 File No.  
 Primary Registration District No. 5405a Registered No. 51  
 (NO. of Ward)

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

FULL NAME Thomas L. Frost

PERSONAL AND STATISTICAL PARTICULARS

2 SEX M. 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED M.  
 (Write the word)  
 6 DATE OF BIRTH  
 (Month) (Day) (Year)  
 7 AGE  
 yrs. mos. ds. If LESS than 1 day, hrs. or min.?  
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
 (City or town, State or foreign country)  
 PARENTS  
 10 NAME OF FATHER  
 11 BIRTHPLACE OF FATHER  
 (City or town, State or foreign country)  
 12 MAIDEN NAME OF MOTHER  
 13 BIRTHPLACE OF MOTHER  
 (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) J. W. Krapf  
 (Address) Hornersville, Mo.

15 Filed 2-16-1916  
E. G. Cape  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 15 1916  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, that I attended deceased from 1916 to 1916  
 that I last saw him alive on 1916  
 and that death occurred, on the date stated above, at 1916  
 The CAUSE OF DEATH\* was as follows:  
Institution supplied.

CONTRIBUTORY (Secondary)  
 (Duration) yrs. mos. ds.  
 (Signed) M. D.  
 (Address) 1916

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, 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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
 1916

20 UNDERTAKER ADDRESS  
J. F. Kussel, Hornersville, Mo.

SUPPLEMENTARY

BANKERS' PROFESSION SUPPLIED

CAUSE OF DEATH... so that it may be properly classified. Exact statement of OCCUPATION is very important.

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*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), *29ds.*; *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 septichaemia," "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.)

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