

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

31887

PLACE OF DEATH
County New Madrid
Township _____
or _____
Village _____
or _____
City Lilbourn (NO. _____ St. _____ Ward _____)

Registration District No. 274 File No. _____
Primary Registration District No. 4063 Registered No. 15

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

FULL NAME Doyle H. White

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)
DATE OF BIRTH Sept 22, 1914
(Month) (Day) (Year)
AGE 1 yrs. 11 mos. 20 ds.
if LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION
(a) Trade, profession, or particular kind of work V
(b) General nature of industry, business, or establishment in which employed (or employer) "

DATE OF DEATH Sept 12, 1916
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Sept 5, 1916, to Sept 12, 1916, that I last saw him alive on Sept 12, 1916, and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Nephritis

BIRTHPLACE (City or town, State or foreign country) Mo
PARENTS
NAME OF FATHER Chas White
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Pearl Gillihan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Malaria
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Edward Bogard M. D.
Sept 12, 1916 (Address) Lilbourn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas white
(ADDRESS) Lilbourn, Mo
Filed Sept 12, 1916 E. B. Jones
REGISTRAR

*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 Mounts Cemetery DATE OF BURIAL Sept 13, 1916
UNDERTAKER J. J. Smoot ADDRESS Lilbourn, Mo

No. 5- 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.)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

1 PLACE OF DEATH *New Madrid*
County *New Madrid*

274
4063

Township *1* Registration District No. *274* File No. *15*
or
Village *Lebourn* Primary Registration District No. *4063* Registered No. *15*
or
City *Lebourn* NO. *NO* St. *NO* Ward *NO*

2 FULL NAME *Doyle White*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OF FACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *W*
(Write the word)

6 DATE OF BIRTH *1* (Month) *1* (Day) *1* (Year)

7 AGE *1* yrs. *1* mos. *1* 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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *9-12-16*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *9-12-16* 191*6* to *9-12-16* 191*6*, that I last saw him *alive*, or that death occurred, on the date stated above, at *Lebourn Mo* m. The CAUSE OF DEATH* was as follows: *Acute Nephritis*
119 (Duration) yrs. mos. ds.
Malaria
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
Edward Bogard (Signed) *9-12-16* (Address) *Lebourn Mo*

*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, 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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *E. E. Jones*
(Address) *Lebourn Mo*

15 Filed *Sept 12 1916* 191*6* *E. E. Jones* Registrar

SATISFACTORY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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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 "Asthēnia," "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.)