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

PLACE OF DEATH

County Audrain

Township or Village Laddonia or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 24 — File No. 4551

Primary Registration District No. 4018 — Registered No. ____

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

FULL NAME Joseph Martin Culbertson

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: March (Month) 26 (Day) 1832 (Year)

AGE: 84 yrs. 11 mos. 19 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Doing Nothing
(b) General nature of industry, business, or establishment in which employed (or employer): " "

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

PARENTS
NAME OF FATHER: Joseph Culbertson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky
MAIDEN NAME OF MOTHER: S Griffith
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Culbertson

(ADDRESS) Jefferson City, Mo

Filed Mch 17 1917 T M Monroe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. (Month) 17 (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1917, to Feb 17, 1917, that I last saw him alive on Mch 17, 1917, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Senility
1860
1896
1902

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): Fractured Shoulder

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) T M Monroe M. D.

____ 191__ (Address) ____

*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 14 yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

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

Former or usual residence: dont Know

PLACE OF BURIAL OR REMOVAL: Vandalia Mo

DATE OF BURIAL: Mch 19 1917

UNDERTAKER: H. G. Granger

ADDRESS: Laddonia Mo

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

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
_____, 191____
(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:

_____

_____

_____

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

Contributory _____
(Secondary)

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

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

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

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

1 PLACE OF DEATH

County: Andrew

Township: ..... or

Village: ..... or

City: ..... (NO. ....., ... St.; ..... Ward)

Registration District No.: 24

Primary Registration District No.: 4018

File No.: .....

Registered No.: .....

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

2 FULL NAME: Joseph Martin Culverson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): W

6 DATE OF BIRTH: Sept (Month) ..... (Day) 1 (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): .....

(Address): .....

15 Filed: Mch 17, 1917 T. M. Monroe, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May ~~Feb~~ 17 (Month) ..... (Day) 1917 (Year)

17 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:

Gunshot Shock from injury accidental

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

CONTRIBUTORY (Secondary): Fracture Shoulder by fall

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed): T. M. Monroe M. D.

3-19, 1917 (Address): Laddonia

*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: Vandalia Mo.

DATE OF BURIAL: 3-19-1917

20 UNDERTAKER: H. G. Grange

ADDRESS: Laddonia Mo

Original file, date: ~~Feb~~ March, 1917

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Supplementary Information Supplied

Supplementary Information Supplied

Supplementary Information Supplied

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), *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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