

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

PLACE OF DEATH
County Newton
Township Franklin
or
Village Trans-Hew
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 608 File No. 27 - 2476
Primary Registration District No. 5807a Registered No. _____

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

FULL NAME Robert Samuel Carpenter

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married
OR WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH September 6th 1868
(Month) (Day) (Year)
AGE 50 yrs. 4 mos. 21 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) Missouri

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 27, 1919
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from January 3, 1919, to January 27, 1919, that I last saw him alive on January 27, 1919 and that death occurred, on the date stated above, at 4:45 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma
65
(Duration) _____ yrs. 11 mos. _____ ds.

PARENTS
NAME OF FATHER Geo. W. Carpenter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
MAIDEN NAME OF MOTHER Hettie A. Pulley
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

Contributory (Secondary) F. (Mortuo, Mo.)
Paul W. Benton (Duration) 2 or 6 yrs. _____ mos. _____ ds.
(Signed) A. C. Swindle M.D.
Jan. 27, 1919 (Address) Fairview, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James W. Carpenter
(ADDRESS) Pisarees, 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 _____

Filed Jan 27 1919 L N Barnett
REGISTRAR

PLACE OF BURIAL OR REMOVAL W. Olin Cem. Newton, Mo. DATE OF BURIAL Jan 28, 1919
UNDERTAKER J N White ADDRESS Fairview, Mo.

PLACE OF DEATH

County W. R. W. 1873
 Township _____
 or Village _____
 or City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 (NO. _____ St. _____ Ward _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If give the word)
DATE OF BIRTH	(Month) _____ (Day) <u>7</u> (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)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attest that I last saw h _____ alive on _____, 191____, to _____ and that death occurred, on the date stated, _____

The CAUSE OF DEATH* was as follows:

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER _____ (Duration) _____ yrs.

BIRTHPLACE OF FATHER _____ (Duration) _____ yrs.
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____, 191____ (Address) _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS)

PLACE OF BURIAL OR REMOVAL _____ DAT _____

UNDERTAKER _____ AD _____

PARENTS

HTBIB
 DATE
 AM

**MISSOURI STATE BOARD
 BUREAU OF VITAL ST
 CERTIFICATE OF DE**

12-15-11
 100
 101
 102
 103
 (a)
 104
 105
 106
 107
 108
 109
 110

Filed _____, 191____

REGISTRAR

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Newton
Township Franklin
City (No.) St. Ward

Registration District No. 608
Primary Registration District No. 5807A

File No.
Registered No. 27
St. Ward

2. FULL NAME

Robert Samuel Carpenter

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 19 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of the Caecum

CONTRIBUTORY (SECONDARY) H (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

rhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

[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

2476
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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.