

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

32153a

1 PLACE OF DEATH
County Stark
Township Lincoln
or
Village
or
City

Registration District No. 1044 File No. 7
Primary Registration District No. 625-9 Registered No. 7
(NO. St. Ward)

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

2 FULL NAME Frank Bauling

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH Feb 14 1887
(Month) (Day) (Year)

7 AGE 7 2 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Tenn

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben F Bauling
(Address) Stalena

15 Filed 10-6 1919 Thos H Haultz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 4 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 15, 1919, to Oct 4, 1919, that I last saw him alive on Oct 1, 1919, and that death occurred, on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) 4 yrs. 7 mos. 22 ds.

CONTRIBUTORY (Secondary)
(Duration) 4 yrs. 7 mos. 22 ds.
(Signed) W L Stern M. D.
Oct-6-1919 (Address) Craze 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 4 yrs. 7 mos. 22 ds. In the State 4 yrs. 7 mos. 22 ds.
Where was disease contracted if not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Mansfield DATE OF BURIAL 10-6, 1919

20 UNDERTAKER W E Hilton ADDRESS Craze

1 PLACE OF DEATH

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

County
 Township or
 Village or
 City (NO.)
 Registration District No.
 Primary Registration District No.
 Registered No.
 File No. *1000*
 St. (Ward)
 If death occurred in a hospital or institution, give its NAME instead of street and number.

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
 4 COLOR OR RACE
 5 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6 DATE OF BIRTH: (Month) (Day) (Year)
 If LESS than 1 day hrs. or min.?

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)
disciplinarian

9 BIRTHPLACE
 (City or town, State or foreign country)
Missouri

10 NAME OF FATHER
disciplinarian

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

12 MAIDEN NAME OF MOTHER
disciplinarian

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed 1911 Registrar
disciplinarian

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
5-11-1911

17 I HEREBY CERTIFY, that I attended deceased from 1911 (Month) (Day) (Year)
 that I last saw h..... alive on 1911
 and that death occurred, on the date stated above, at
 The CAUSE OF DEATH* was as follows:

 (Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary)
 (Signed) (Duration) yrs. mos. ds.
 1911 (Address) M. D.

*See the Disease Causing Death, or, in death from Violent Causes, see (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 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 1911

20 UNDERTAKER ADDRESS

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

1. PLACE OF DEATH
 County Stone Registration District No. 1044 File No.
 Township Lincoln Primary Registration District No. 6259 Registered No. 7
 City (No.) St. Ward (....)

2. FULL NAME Frank Bainburg
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1919

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Nephritis acuta

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

8. OCCUPATION OF DECEASED

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

(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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

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

DID AN OPERATION PRECEDE DEATH? DATE OF

10. NAME OF FATHER

WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS (Signed) A. L. Kerr M. D.
 , 19 (Address) Crandall mo

12. MAIDEN NAME OF MOTHER

*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.)

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

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

14. INFORMANT (Address)

20. UNDERTAKER ADDRESS

15. FILED 19..... REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

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, 8 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," "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 gives 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.

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