

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

1 PLACE OF DEATH

County Clinton

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Lathrop (NO \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 206

File No. 36406

Primary Registration District No. 4124

Registered No. 27

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

2 FULL NAME John Wadde Carruthers

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 Dec 14 1846  
(Month) (Day) (Year)

7 AGE 74 yrs 10 mos 10 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) Chillicothe City Ohio

PARENTS  
10 NAME OF FATHER Thomas Carruthers  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Dyersville Scot  
12 MAIDEN NAME OF MOTHER Agnes Granger  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dyersville Scot

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Miss E. C. Carruthers  
(Address) Albany Ill

15 Filed Dec. 11 - 1920 J. P. Kinsey Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 10 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 9 1920 to Dec 10 1920 that I last saw him alive on Dec 15 1920 and that death occurred, on the date stated above, at 8:30 am.

The CAUSE OF DEATH\* was as follows:  
Asphyxiation  
Complete prony tie of larynx  
with long spur  
(Duration) yrs. mos. ds. 3 ds.

CONTRIBUTORY (Secondary) nothing known  
(Duration) yrs. mos. ds. \_\_\_\_\_  
(Signed) A. R. Robertson M. D.  
Dec 11, 1920 (Address) Lathrop 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 Lathrop Mo DATE OF BURIAL Dec 12 - 1920

20 UNDERTAKER A. Y. Clepper ADDRESS Lathrop 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, 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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid

1. SEX: M ( ) F ( )

2. AGE: \_\_\_\_\_

3. OCCASION: \_\_\_\_\_

4. PLACE OF BIRTH: \_\_\_\_\_

5. PLACE OF DEATH: \_\_\_\_\_

6. DATE OF DEATH: \_\_\_\_\_

7. TIME OF DEATH: \_\_\_\_\_

8. CAUSE OF DEATH: \_\_\_\_\_

9. MANNER OF DEATH: \_\_\_\_\_

10. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

11. SIGNATURE OF DEATH CERTIFICATE OFFICER: \_\_\_\_\_

12. SIGNATURE OF WITNESSES: \_\_\_\_\_

13. ADDRESS: \_\_\_\_\_

14. CITY: \_\_\_\_\_

15. STATE: \_\_\_\_\_

16. COUNTY: \_\_\_\_\_

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484. STATE: \_\_\_\_\_

485. COUNTY: \_\_\_\_\_

486. ZIP CODE: \_\_\_\_\_

487. NAME OF BUREAU: \_\_\_\_\_

488. DATE OF BIRTH: \_\_\_\_\_

489. ADDRESS: \_\_\_\_\_

490. CITY: \_\_\_\_\_

491. STATE: \_\_\_\_\_

492. COUNTY: \_\_\_\_\_

493. ZIP CODE: \_\_\_\_\_

494. NAME OF BUREAU: \_\_\_\_\_

495. DATE OF BIRTH: \_\_\_\_\_

496. ADDRESS: \_\_\_\_\_

497. CITY: \_\_\_\_\_

498. STATE: \_\_\_\_\_

499. COUNTY: \_\_\_\_\_

500. ZIP CODE: \_\_\_\_\_

MISSOURI STATE IRUOSIS

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_

COUNTY: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

NAME OF BUREAU: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

181