

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

1. PLACE OF DEATH

County Gasconade
Township Reeds
City Reeds (No. _____)

Registration District No. 4/5
Primary Registration District No. 4247

File No. 34709
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Reeds mo St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 24 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 1 14

8. OCCUPATION OF DECEASED Retired
(a) Trade, profession, or particular kind of work Reeds mo
(b) General nature of industry, business, or establishment in which employed (or employer) Reeds mo
(c) Name of employer _____

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

10. NAME OF FATHER Isaac Runner

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT A. L. Runner
(Address) Reeds mo

15. FILED 12/31 19 22 Geoff Bragdon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 30 1922

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922, to Dec 30, 1922, that I last saw him alive on Dec 30, 1922, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suppurative Cholangitis

(duration) _____ yrs. 1 mos. 15 da.
CONTRIBUTORY Influenza
(SECONDARY) (duration) _____ yrs. 0 mos. 7 da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: at above place

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Geoff Bragdon, M. D.
12/31, 1922 (Address) Reeds mo

*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 Clear Water Kansas. DATE OF BURIAL January 1922

20. UNDERTAKER James W. Clark Co. ADDRESS Reeds mo
Reeds 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.

RECORD

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, Composer, 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," "Salesman," 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, 5 yrs.)* For persons who have no occupation whatever, write *Nona.*

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, peritonæum, 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 septicæmia," "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, pyæmia, septicæmia, 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.

CAUSE OF DEATH

*Asper
dysenteria
Reeds*

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

*Sub 412
32709*

Registration District No. *415* File No. _____
Primary Registration District No. *4247* Registered No. _____
(NO. _____ St. _____ Ward _____)

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

NAME *George W. Rumor*

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White*
MARRIED *married*
WIDOWED
OR DIVORCED
(Write the word)
November 24 1885
(Month) (Day) (Year)

77 yrs 1 mos 6 ds
If LESS than 1 day, hrs. or min.?

Retired *Beam Mfg.*
of work.

Maacomb, Ohio.

Isaac Rumor

Virginia

Do not know

Do not know

TRUE TO THE BEST OF MY KNOWLEDGE
G. W. Rumor

Reeds Mo.

1922 Geo. H. Bragdon

Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *December 30 1922*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov 14 1922 to Dec 30 1922*

that I last saw him alive on *Dec 30 1922*

and that death occurred, on the date stated above, at *3.30 P.M.*

The CAUSE OF DEATH* was as follows:
Suppurative Cholangitis

(Duration) _____ yrs _____ mos _____ ds.

CONTRIBUTORY *Influenza*
(Secondary) (Duration) _____ yrs _____ mos _____ ds.

(Signed) *Geo. H. Bragdon* M. D.
12/31 1922 (Address) *Reeds 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? *at place of death*

Former or usual residence *Anderson Mo.*

19 PLACE OF BURIAL OR REMOVAL *Clearwater, Kans.* DATE OF BURIAL *July 2, 1923*

20 UNDERTAKER *Saronic Fun. & Rest Co.* ADDRESS *Saronic Mo.*

Carroll County, Mo. 1922

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
COMMISSIONER

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF

MISSOURI STATE BOARD BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1 PLACE OF DEATH

County
 Township Registration District No. File No.
 or
 Village Primary Registration District No. Registered No.
 or
 City (NO St. Ward)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
 (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)

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 191 Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
 (Month)

17 I HEREBY CERTIFY, that I attended
 191 to
 that I last saw h alive on
 and that death occurred, on the date stated above
 The CAUSE OF DEATH* was as follows:

..... yrs. (Duration) yrs.
 (Duration) yrs.
 CONTRIBUTORY (Secondary)
 (Signed) 191 (Address)

*State the Disease Causing Death, or, in deaths from Violence,
 (1) Means of Injury; and (2) whether Accidental, Suicide
 or Recent Residents)
 18 LENGTH OF RESIDENCE (For Hospitals, Institutions
 or Recent Residents)
 At place of death yrs. mos. ds. State yrs.
 Where was disease contracted
 if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

20 UNDERTAKER

DATE C
 ADDRE