

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

PLACE OF DEATH

County Barry

Township _____

Registration District No. 39

File No. 7340

Village _____

Primary Registration District No. 4021

Registered No. 95

City Cassville Mo. (NO. _____)

St. _____ Ward _____

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

FULL NAME

Arthur Grant Hoark

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Widowed?
WIDOWED Married
OR DIVORCED _____
(Write the word)

DATE OF DEATH March 9th, 1915
(Month) (Day) (Year)

DATE OF BIRTH August 14th, 1885
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Killed instantly by Pistol Shot wound, self-inflicted
that I last saw him alive on March 9th, 1915;

AGE 39 yrs. 6 mos. 25 ds. if LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at about 9:10 P. m.
The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Rail Road Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Pistol Shot Wound, self-inflicted
107

BIRTHPLACE (City or town, State or foreign country) Cassville Mo.

(Duration) 1 yrs. _____ mos. _____ ds.

NAME OF FATHER Jacob W. Hoark

Contributory None Known
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER Warren Co. Tenn.

(Signed) D. S. Mitchell M. D.
March 10th, 1915 (Address) Cassville Mo.

MAIDEN NAME OF MOTHER Addie Graston

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER Indiana

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. B. Hones

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) Cassville Mo.

PLACE OF BURIAL OR REMOVAL Oak Hill Cemetery DATE OF BURIAL March 10th, 1915

Filed March 10th, 1915, D. S. Mitchell M. D. REGISTRAR

UNDERTAKER P. E. Hones ADDRESS Cassville 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, 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, meningis, 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), *29 ds.*; *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 septicaemia," "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.)

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.

PLACE OF DEATH Barry County _____
 or _____
 Township _____ Registration District No. 29 File No. _____
 or _____
 Village Cassville Primary Registration District No. 4021 Registered No. 95
 or _____
 City Cassville (NO. _____) St. _____ Ward _____
 FULL NAME Arthur Grant Hawk [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Widow
 (# write the word)

DATE OF DEATH 3 / 9 1915
 (Month) (Day) (Year)

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

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h _____, 191____,
 and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* was as follows:
Pistol shot wound self
inflicted
with suicidal intent

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

Contributory Don't Know
 (Duration) _____ yrs. _____ mos. _____ ds.

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) _____

(Signed) D. J. Mitchell M.D.
3/10 1915 (Address) Cassville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

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____
 ADDRESS _____

Filed March 10th 1915 D. J. Mitchell M.D.
 REGISTRAR

UNDERTAKER _____
 ADDRESS _____

SATISFACTORY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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