

WRITE PLAINLY UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

12178

PLACE OF DEATH
County Dickson
Township Grant
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 264
Primary Registration District No. 5369

File No. _____
Registered No. _____

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

FULL NAME John T. Cogdill

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Dec. 20, 1869
(Month) (Day) (Year)

AGE 60 yrs. 4 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Dickson Co

PARENTS
NAME OF FATHER James Cogdill
BIRTHPLACE OF FATHER (City or town, State or foreign country) Louisiana
MAIDEN NAME OF MOTHER Emilia Franz
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Cogdill
(ADDRESS) Mayouelle 5no

Filed _____, 1913

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 29th, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 29th, 1930, to April 29th, 1930, that I last saw him alive on April 10th, 1930, and that death occurred, on the date stated above, 2 P. m.

The CAUSE OF DEATH* was as follows:
Acute myocarditis
BBB 937
1150
678
(Duration) ___ yrs. ___ mos. 2 hours

Contributory Toxemia from alveolar abscesses (Duration) 10 yrs. ___ mos. ___ ds.

(Signed) J. S. Johnson M. D.
April 30, 1930 (Address) Mayouelle 5no

*State the Disease Causing Death, or, in death 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 _____

PLACE OF BURIAL OR REMOVAL Burton Cem. DATE OF BURIAL 5/1, 1930

UNDERTAKER U. G. Pilcher ADDRESS Mayouelle 5no

REGISTRAR

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, 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," "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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County DeKalb Registration District No. 264 File No. _____
 Township Grant Primary Registration District No. 5369 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

John T. Cogdell
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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) Dec 20 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 4 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (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) DeKalb Ga.

10. NAME OF FATHER

James Cogdell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER

Emilia Franz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ky.

14.

INFORMANT Carl Cogdell
 (Address) Maysville mo.

15.

FILED June 20 1930 MRS. Kucalinski REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 29 1930

17. I HEREBY CERTIFY That I attended deceased from April 29 to April 29, 1930
 that I last saw h. alive on Apr 10, 1930, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute myocardia
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY Toxemia from alveolar abscess (duration) 10 yrs. _____ mos. _____ da.
 (SECONDARY)

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) G. D. Johnson, M. D.

4/30 1930 (Address) Maysville

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Butler Cem. 5/1 1930

20. UNDERTAKER

ADDRESS

U. G. Pilcher Maysville mo.

WRITE PLAIN. WITH INK. THIS IS A PERMANENT RECORD.

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SUPPLEMENTARY

S-12178