

WRITE PLAINLY, WITH 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

PLACE OF DEATH

County Jackson
Township _____
or
Village _____
or
City N. S. Mo. (NO. Shesley Hospital St. _____ Ward _____)

Registration District No. 399 File No. 1878
Primary Registration District No. 1002 Registered No. 611

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

FULL NAME John Little

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 26, 1844
(Month) (Day) (Year)

AGE 63 yrs. 11 mos. 26 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) Indiana

PARENTS NAME OF FATHER Thomas Little

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

MAIDEN NAME OF MOTHER Susan Gray

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Bussey

(ADDRESS) Bussey Iowa

Filed FEB 22 1910

1910 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 20, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12:30 P.M. Feb. 20, 1910, to 6:00 P.M. Feb. 21, 1910, that I last saw him alive on Oct. 20, 1910, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

meningitis
89 B
99 B
(Duration) ___ yrs. ___ mos. 2 ds.

Contributory Mastoid abscess
(SECONDARY) (Duration) ___ yrs. ___ mos. 6 ds.

(Signed) Oliver P. Fairies M. D.
Feb 9, 1910 (Address) 1203 E. 8. St.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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. 4 ds. in the State ___ yrs. ___ mos. 4 ds.

Where was disease contracted if not at place of death? Iowa, Kas

Former or usual residence Iowa, Kas.

PLACE OF BURIAL OR REMOVAL Iowa, Kas. DATE OF BURIAL Feb 22, 1910

UNDERTAKER Harriweather Smith ADDRESS 2120 E. 10th

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, peritonaeum*, etc., *Carcinoma*, *Sar-*

coma, 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.)



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

PLACE OF DEATH Jackson
 County Jackson
 Township _____
 or
 Village H. C. Mo
 or
 City H. C. Mo (NO. Wesley Hospital St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Registration District No. 299 File No. 1878
 Primary Registration District No. 1002 Registered No. 611

FULL NAME John Little

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
 DATE OF BIRTH March 26 1844
 (Month) (Day) (Year)
 AGE 63 yrs. 11 mos. 26 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) Indiana
 NAME OF FATHER Thos. Little
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
 MAIDEN NAME OF MOTHER Cassam Fry
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. C. Bussery
 (ADDRESS) Bussery Town
 FINGER Feb 22 1910 REGISTRAR W. B. Davis

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 20, 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 20, 1910, to Feb. 20, 1910, that I last saw him alive on Feb. 20, 1910, and that death occurred, on the date stated above, at 6P m.
 The CAUSE OF DEATH* was as follows:
Exanthematous

Contributory Mastered Abscess
 (SECONDARY) (Duration) ____ yrs. ____ mos. 2 ds.
 (Signed) Alneas P. James M. D.
Feb 21 1910 (Address) 1342 8 St

*State the Disease Causing Death, or, in deaths 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. 4 In the State ____ yrs. ____ mos. 4 ds.
 Where was disease contracted if not at place of death? Tran. Kas.
 Former or usual residence Tran. Kas.

PLACE OF BURIAL OR REMOVAL Tran. Kas. DATE OF BURIAL Feb 22, 1910
 UNDERTAKER Tran. Kas. ADDRESS 2120 E. 15th

2/22/10 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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coma, 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.)