

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 Davis

Township _____

Registration District No. 252

File No. 33785

Village _____

Primary Registration District No. 4152

Registered No. 15

City Jamesport (NO. _____)

St. _____ Ward _____

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

FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

DATE OF BIRTH November 20th, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 20, 1910, to Nov 20, 1910, that I last saw him alive on Nov. 20, 1910, and that death occurred, on the date stated above, at 5 A. m.

AGE One Hour If LESS than 1 day, 1 hrs. or 1 min.?

The CAUSE OF DEATH* was as follows:
Still Born
No Cause

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

BIRTHPLACE (City or town, State or foreign country) Jamesport

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

NAME OF FATHER Morgan Hill Jr.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER Stanhope Iowa

(Signed) R. J. Thompson M. D. (Address) Jamesport Mo.

MAIDEN NAME OF MOTHER Bessie King

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

BIRTHPLACE OF MOTHER Bradgate Iowa

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) Morgan Hill Jr.

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL 200th Cemetery DATE OF BURIAL _____ 1910

Filed Nov 26, 1910. C. M. C. Spivey REGISTRAR

UNDERTAKER J. P. Burren ADDRESS Jamesport

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," "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*, *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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PLACE OF DEATH

County Ravess
Township Jamesport
or
Village
or
City

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 252
Primary Registration District No. 4152

File No. 33785
Registered No. 15

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

FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>mail</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>November 20th 1910</u> (Month) (Day) (Year)		IF LESS than 1 day, ___ hrs. or ___ min.?
AGE <u>One hour</u> yrs. mos. ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Nov. 20, 1910 to Nov. 20, 1910, that I last saw him alive on Nov. 20, 1910, and that death occurred, on the date stated above, at 5 a m. The CAUSE OF DEATH was as follows:
Still Born.

BIRTHPLACE
(City or town, State or foreign country)
Jamesport

PARENTS	NAME OF FATHER <u>Morgan Hill</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Stanhope Iowa</u>
	MAIDEN NAME OF MOTHER <u>Ressie A King</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Bradgate Iowa</u>

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. J. Thompson
Nov. 20, 1910 (Address) Jamesport, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Morgan Hill Jr
(ADDRESS) Jamesport 2nd

*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. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?
Former or usual residence.

Filed Nov 26 1910 C. J. McKinley
REGISTRAR

PLACE OF BURIAL OR REMOVAL
2007 Cemetery

DATE OF BURIAL
Nov 20, 1910

UNDERTAKER
J. O. Burren

ADDRESS
Jamesport Mo

Revised United States Standard Certificate of Death

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

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