

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

PLACE OF DEATH

County St. Louis
Township Carranet
or
Village _____
or
City Quarantine (NO. Quarantine Hospital St. _____ Ward _____)

Registration District No. 7 File No. 35501
Primary Registration District No. 6248 Registered No. 239

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

FULL NAME William A. Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
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DATE OF BIRTH July 11, 1866
(Month) (Day) (Year)

AGE 44 yrs. 3 mos. 28 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS	NAME OF FATHER <u>F. P. Jones</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>
	MAIDEN NAME OF MOTHER <u>Melrina Gall</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Fehl. Hospital Information
(ADDRESS) Quarantine Hospital

Filed Nov. 10 1910 L. P. Brock M.D. REGISTRAR
L. P. Brock M.D.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 9, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 4, 1910, to Nov 9, 1910, that I last saw him alive on Nov 9, 1910, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis
23A
241
132 (Duration) yrs. mos. ds.

Contributory Nephritis & B. Meningitis
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) M. J. Dwyer M. D.
Nov 9, 1910 (Address) Quarantine

* 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. 5 ds. In the 12 yrs. 3 mos. 29 ds.
Where was disease contracted if not at place of death? do not know
Former or usual residence. 1145 Palmyra ave

PLACE OF BURIAL OR REMOVAL <u>Dundee Mo.</u>	DATE OF BURIAL <u>Nov. 11, 1910</u>
UNDERTAKER <u>Geo. Kriegerman 212 S. 1102 Manhattan</u>	ADDRESS

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 healthness of various pursuits can be known. The question applies to each and every person, irrespective of

For many occupations a single word or term on first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *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) *Miner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material entered on may form part of the second statement.

For return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification, as *laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. For persons 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*, *Housewife*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to re-mention specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housewife*, etc. If the occupation has been changed or given account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business of (A) that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation at death, 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 term for the same disease. Examples: *Cerebral fever* (the only definite synonym is "Epidemic spinal meningitis"); *Diphtheria* (avoid use of "p"); *Typhoid fever* (never report "Typhoid onia"); *Lobar pneumonia*; *Bronchopneumonia* (*pneumonia*, unqualified, is indefinite); *Tuberculosis*, *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.)

HUGH STEPHENS, JEFFERSON CITY.

