

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

PLACE OF DEATH

County Ozark
Township Marion
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 649 File No. 2735

Primary Registration District No. 5860 Registered No. _____

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

FULL NAME Melinda Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE American SINGLE MARRIED Widow WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH unknown unknown 1892
(Month) (Day) (Year)

AGE 28 yrs. unknown mos. unknown ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

BIRTHPLACE (City or town, State or foreign country) Needville Vir

PARENTS
NAME OF FATHER Johnson
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
MAIDEN NAME OF MOTHER unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Daniels
(ADDRESS) Toledo Mo

Filed Jan 10 1911 J. B. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 10, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1910, to Dec 10, 1910, that I last saw her alive on Dec 9, 1910, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:
Pneumonia
109A

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

(Signed) Dr. Daniels M. D.
Jan 10 1911 (Address) Toledo Mo

*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 _____

PLACE OF BURIAL OR REMOVAL Bechel DATE OF BURIAL Dec 11 1910
UNDERTAKER Neighbors ADDRESS _____

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____)

St.: _____ Ward) _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-----|---------------------------------|---|
| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| | DATE OF BIRTH | (Month) _____, _____, 191____ (Day) _____ (Year) _____ |
| AGE | _____ yrs. _____ mos. _____ ds. | if LESS than 1 day, _____ hrs. or _____ min.? |

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) _____

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____, 191____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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

Contributory

(SECONDARY)

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

(Signed) _____

_____, 191____ (Address) _____ M. D.

* 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 HOSPITAL 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____

UNDERTAKER _____

ADDRESS _____

PLACE OF DEATH

County Ozark
 Township Marion
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 649
 Primary Registration District No. 2860

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

File No. 2735
 Registered No. _____

FULL NAME

Malinda Johnson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE American SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF BIRTH unknown, 1892
(Month) (Day) (Year)

AGE 78 yrs. unknown mos. unknown ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
 (City or town, State or foreign country) Sneedsville, Vir.

NAME OF FATHER Johnson

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

MAIDEN NAME OF MOTHER unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Daniels
 (ADDRESS) Toledo, Mo.

Filed Jan 10 X 1911 J. R. Davis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 10, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 10, 1910, to Dec. 10, 1910, that I last saw deceased on Dec. 9, 1910, and that death occurred, on the date stated above, at 2-9 m. The CAUSE OF DEATH* was as follows:

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

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

(Signed) Dr. Daniels M. D.
Jan. 10, 1911 (Address) Toledo, Mo.

*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 _____

PLACE OF BURIAL OR REMOVAL Bethel DATE OF BURIAL Dec 11, 1910

UNDERTAKER Mighbars (?) ADDRESS McClung Mo

All information called for must be written on this Supplementary Certificate.

JAN

CAUSE OF DEATH in plain terms, so that it may be properly classified. Birth date of informant of C. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

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, 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.)