

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 Laclede Registration District No. 449 File No. 31809
Township Debanon or Debanon Primary Registration District No. 447 Registered No. 5209
Village _____ or _____ City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Joseph William Owen

PERSONAL AND STATISTICAL PARTICULARS

5 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF DEATH Sept 10, 1911
(Month) (Day) (Year)

DATE OF BIRTH Oct 24, 1882
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Debanon, 1911, to Oct 24, 1911, that I last saw h alive on Oct 4, 1911,

AGE 82 yrs. 10 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 4 p. m.

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

The CAUSE OF DEATH* was as follows:

BIRTHPLACE (City or town, State or foreign country) Kentucky, Holt Co.

Decline in heart
135-138 1330
Contributory
(Duration) yrs. one mos. _____ ds. _____

PARENTS NAME OF FATHER Peter Owen

(Signed) J. H. Cooper
(Address) _____
*State the Disease Causing Death, or, (1) Means of Injury; and (2) whether Accident or Not.

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

PARENTS MAIDEN NAME OF MOTHER Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. P. Owen

(ADDRESS) Oakland Ave

Filed _____ 1911 REGISTRAR

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 Pres 500th St DATE OF BURIAL Sept-11, 1911

UNDERTAKER Pres 500th St ADDRESS Debanon

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*, *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.)



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

PLACE OF DEATH
 County Laclede
 Township Lebanon
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. H 49 File No. _____
 Primary Registration District No. 5-609 Registered No. _____

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

FULL NAME Joseph William Owen

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF BIRTH Oct 24, 1882
(Month) (Day) (Year)

AGE 82 yrs 10 mos 16 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) _____

BIRTHPLACE (City or town, State or foreign country) Hart Co. Kentucky

PARENTS
 NAME OF FATHER Peter Owen
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
 MAIDEN NAME OF MOTHER Ann Brown
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. Pawver
 (ADDRESS) Oakland Mo

Filed Nov 3 1911 J. M. Bellamy
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 10, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 7, 1911, to Oct 24, 1911, that I last saw h alive on Oct 6, 1911, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Dr. decline incident to
Old age - kidney &
bladder disease.
dropsy of heart. Mitral
insufficiency and general
 Contributory of aorta
(SECONDARY)
 (Duration) 1 yrs. 1 mos. 0 ds.

(Signed) T. H. Casey M. D.
Oct 24 1911 (Address) Lebanon

*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 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds.
 Where was disease contracted If not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Wass Mo DATE OF BURIAL Sept 11, 1911
 UNDERTAKER Ross Hickman ADDRESS Lebanon

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association)

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