

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 Howell
Township Howell
or
Village _____
or
City _____ (NO. _____) (St. _____) (Ward _____)

Registration District No. 384 File No. 37758
Primary Registration District No. 5535 Registered No. 149

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

FULL NAME James W Dixon

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
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DATE OF BIRTH No means of knowing
(Month) (Day) (Year)

AGE About 50 yrs. mos. ds.
IF LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Not known
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

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

PARENTS	NAME OF FATHER <u>Not known</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>
	MAIDEN NAME OF MOTHER <u>Not known</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) No informant
(ADDRESS) _____

Filed 11-4- 1911 D.J. Nichols
By O. A. Steunch, D.R. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November 3d, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 3d, 1911, to Nov 3, 1911, that I last saw him alive on Nov 3d, 1911, and that death occurred, on the date stated above, at 9-P m. The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
died suddenly in County house
History is unknown
871-1 (Duration) yrs. 6 mos. 4 ds.

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

(Signed) D.J. Nichols M. D.
11-4- 1911 (Address) West Plains 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 <u>County farm cemetery</u>	DATE OF BURIAL <u>11-5-</u> 191 <u>1</u>
UNDERTAKER <u>Geo. Hilton</u>	ADDRESS <u>West Plains, Mo</u>

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.)

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County Hawell
Township Hawell
or
Village
or
City

Registration District No. 384 File No. _____

Primary Registration District No. 55-35 Registered No. 149

(NO. Qu County Farm St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James M. Dixon

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE wh. SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) married

DATE OF BIRTH No means of knowing
(Month) (Day) (Year)

AGE about 5-9 mos. ds. IF LESS than 1 day, hrs. or mts.

OCCUPATION (a) Trade, profession, or particular kind of work Not known
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS 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) No Informant

(ADDRESS) _____

Filed 11-4-1911 by D. J. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 3 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 3, 1911, to Nov 3, 1911, that I last saw him alive on Nov 3, 1911, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage, died suddenly in patient's house - history is unknown
(Duration) yrs. mos. ds.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
(Signed) D. J. Nichols M. D.
11-4, 1911 (Address) West Plains

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

PLACE OF BURIAL OR REMOVAL County Farm Cem DATE OF BURIAL 11-5 1911
UNDERTAKER Geo Nelson ADDRESS West Plains

Original file, date NOV 11, 1911

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

SUPPLEMENTARY

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 septichaemia," "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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