

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 Randolph
 Township _____
 or
 Village _____
 or
 City Moberly (NO. 629 Courcannon St. 4th Ward)

Registration District No. 735 File No. 28921
 Primary Registration District No. 3094 Registered No. 157

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

FULL NAME John Finn

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widower
(If write the word)

DATE OF BIRTH Don't know
(Month) (Day) (Year)

AGE about 87 yrs. — mos. — 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) none

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 5, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 3, 1911, to Nov 5, 1911, that I last saw him alive on Nov 5, 1911, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. 2 ds.

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

PARENTS
 NAME OF FATHER Don't know
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know
 MAIDEN NAME OF MOTHER Don't know
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

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

(Signed) O O Ash M. D.
Nov 6, 1911 (Address) Moberly Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Finn
 (ADDRESS) Moberly 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 _____

Filed 11-8- 1911 W. B. Clegg REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Mary's Cemetery DATE OF BURIAL Nov 7, 1911
 UNDERTAKER Martha + Mahan ADDRESS Moberly Mo

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 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.)



PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

County Waudolph
Township _____
Village _____
City Moberly

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

CERTIFICATE OF DEATH

Registration District No. 735 File No. 38921
Primary Registration District No. 0034 Registered No. 157

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

FULL NAME

John Finn

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE W
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

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

AGE about 87 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) _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Finn
(ADDRESS) Moberly

Filed 11-8-1911 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-5, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
11/5, 1911, to 11/5, 1911,
that I last saw him live on 11/5, 1911,
and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:
X Brouche Pneumonia

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

(Signed) _____ M. D.
11-6-1911 (Address) Moberly

*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 St. Marys Cem. DATE OF BURIAL 11-7, 1911

UNDERTAKER Martin Mahan ADDRESS Moberly

SUPPLEMENT

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 *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.)