

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should state

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

PLACE OF DEATH

County Stair
Township Washington
or
Village Green
or
City Green (NO. _____ St. _____ Ward _____)

Registration District No. 843 File No. 40207

Primary Registration District No. 6106 Registered No. 29

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

FULL NAME James Albert McCoon

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH June 15, 1874
(Month) (Day) (Year)

AGE 36 yrs. 4 mos. 3 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) None

BIRTHPLACE (City or town, State or foreign country) Stone Co Mo

NAME OF FATHER John C McCoon

BIRTHPLACE OF FATHER (City or town, State or foreign country) Green Co Mo

MAIDEN NAME OF MOTHER Virginia Jarrett

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Green Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John C McCoon

(ADDRESS) Reed Spring Mo

Filed Nov 8 1917 J. McCoon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 6 1917
(Month) (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:
Tuberculosis
No Doctor

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 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 Galena Cemetery DATE OF BURIAL Nov 7 1917

UNDERTAKER _____ ADDRESS _____

N. B.—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.....
 Township..... or Village..... or City.....
 Registration District No. File No.
 Primary Registration District No. Registered No.
 (NO.)..... St. Ward).....
 (If death occurred hospital or institute give its NAME and 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)....., I..... (Day)....., I..... (Year).....
AGE..... yrs..... mos..... ds.....
If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
 (a) Trade, profession, or business, or establishment in which employed (or employer).....
 (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....., 19..... (Month)..... (Day)..... (Y).....

I HEREBY CERTIFY, that I attended deceased
 191....., to....., 19.....
 that I last saw h..... alive on....., 19.....
 and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

..... (Duration)..... yrs..... mos.....
 (Duration)..... yrs..... mos.....
Contributory
 (SECONDARY)..... (Address).....
 (Signed).....

* State the Disease Causing Death, or, In deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)
 At place of death..... yrs..... mos..... ds..... State..... yrs..... mos.....
 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 Stone
 Township Washington
 or
 Village
 or
 City _____ (NO. _____ St.: _____ Ward _____)

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

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

Registration District No. 843 File No. 40207
 Primary Registration District No. 6106 Registered No. 29

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

FULL NAME James Albert McClracken

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 5, 1874
 (Month) (Day) (Year)

AGE 36 yrs. 4 mos. 3 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) Don't know

BIRTHPLACE (City or town, State or foreign country) Stone Co. Mo.

PARENTS
 NAME OF FATHER John C. McClracken
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Green Co. Mo.
 MAIDEN NAME OF MOTHER Virginia Jarrett
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Green Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John C. McClracken
 (ADDRESS) Reed Springs Mo.

NOV 8 1911 J. M. Goidt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov-6, 1911
 (Month) (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:
Tuberculosis - no doctor.

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Don't know
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____ 191____ (Address)

*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 Galena Cemetery DATE OF BURIAL Nov-7 1911
 UNDERTAKER Don't know 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 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.)