

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

PLACE OF DEATH

County

Howell
Spring Creek

Township

Village

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

967

5539

41299

20

(NO.

St.:

Ward)

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

FULL NAME

John Holtz

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Male

White

Child

DATE OF BIRTH

Oct 22

909

AGE

2

1 yrs. *19* mos. *13* ds.

If LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION

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

Child

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

BIRTHPLACE

(City or town, State or foreign country)

Illinois

PARENTS

NAME OF FATHER

Charles M. Holtz

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

Illinois

MAIDEN NAME OF MOTHER

Anna E. McGee

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

Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Charles M. Holtz
Quincy, Mo.

Filed

12/3

J. B. Bingham

REGISTRAR

DATE OF DEATH

Dec

3

191*1*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from *Dec. 1*, 191*1*, to *Dec. 3*, 191*1*, that I last saw him alive on *Dec. 2*, 191*1*, and that death occurred, on the date stated above, at *6 P. M.* The CAUSE OF DEATH* was as follows:

Inflammation of bowel

Contributory

(SECONDARY)

1911 (Duration) yrs. *8* mos. *8* ds.

(Signed)

J. B. Bingham M. D.
12/3 191*1* (Address) *Quincy, 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

DATE OF BURIAL

Quincy, Mo.

12/4 191*1*

UNDERTAKER

ADDRESS

C. Davis

Quincy, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

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.)



MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Howell
Township Spq Creek
or
Village
or
City

Registration District No. 967 File No. 41299
Primary Registration District No. 5539 Registered No. 20
(NO. St. Ward)

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

FULL NAME Jno Baker

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 10/22, 1909
(Month) (Day) (Year)

AGE 2 yrs. 1 mos. 13 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 Chas Mother

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

MAIDEN NAME OF MOTHER May J. Collins

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas M. Gypse
(ADDRESS) house

Filed 12/3, 1911 REGISTRAR J. Bingham

Original file, date DEC 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1/13, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12/17, 1911, to 1/13, 1911, that I last saw him alive on 1/12, 1911, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Inflammation of bowels
This inflammation was caused by eating lit oysters about 1909
which had resulted in cholera
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Nothing that I know of
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. Bingham M. D.
12/68, 1911 (Address) Chas. Collins

* 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 Westlister Lane DATE OF BURIAL 1/14, 1911

UNDERTAKER L. Davis ADDRESS Center

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

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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