

County Cape Girardeau Registration District No. 122 File No. E 407  
 Township Welch Primary Registration District No. 5775 Registered No. 5  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME James W. Wells

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married  
 (Write the word)  
 DATE OF BIRTH Oct. 7, 1882  
 (Month) (Day) (Year)  
 AGE 29 yrs. 3 mos. 3 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 OCCUPATION Timberman Tobacco  
 (Trade, profession, or particular kind of work)  
 (General nature of industry, business, or establishment in which employed (or employer)) 1-06

BIRTHPLACE Mattoon, Ind.  
 (City or town, State or foreign country)

NAME OF FATHER William Wells  
 (Surname)

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

MAIDEN NAME OF MOTHER Mary R. Nicholas

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant W. M. Wells

(ADDRESS) Allenville, Mo.

Dated Jan 9, 1912 E. E. Heigdon  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 7, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 5, 1912, to Jan 7, 1912, that I last saw him alive on Jan 5, 1912, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Constricting chills  
38 X  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory

(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. M. Murphy M. D.  
Jan 7, 1912 (Address) Wellington

\*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 Wesley Cemetery DATE OF BURIAL Jan 8, 1912

UNDERTAKER H. H. Hinton ADDRESS Allenville

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

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_ File No. \_\_\_\_\_  
 or Village \_\_\_\_\_ Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 or City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 [If death occurred in hospital or institution, give its NAME last of street and number.]

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, 191\_\_\_\_, I \_\_\_\_\_ (Year)  
 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ 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) \_\_\_\_\_

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 \_\_\_\_\_, 191\_\_\_\_, (Day) \_\_\_\_\_, (Year) \_\_\_\_\_  
 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

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

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.  
 \_\_\_\_\_ (Address) \_\_\_\_\_

**Contributory**  
(SECONDARY)

(Signed) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

\*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 \_\_\_\_\_

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

County Weld REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. File No. 407 Registered No. 5 District No. 5-175 122

FULL NAME James Wm Wills

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Oct 7 1882 (Month) (Day) (Year)

AGE 29 yrs. 3 mos.  ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Mattson Ind.

NAME OF FATHER William Wills

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

MAIDEN NAME OF MOTHER Mary A. Huber

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jm Wills

(ADDRESS) Alleenville Mo

Filed Jan 9 1912 E.E. Higdon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 7 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6 1912 to Jan 7 1912, that I last saw him alive on Jan 7 1912, and that death occurred, on the date stated above, at 4 P m. The CAUSE OF DEATH\* was as follows:

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

(Signed) A.M. Murphy M. D. \*Mar 14 1912 (Address) Whitebater

\*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 Kynin Cem DATE OF BURIAL Jan 8 1912

UNDERTAKER A.H. Hinton ADDRESS Alleenville Mo

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]

**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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