

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

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PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County <u>Greene</u>			Registration District No. <u>318</u>		File No. 318 <u>871</u>
Township _____ or Village _____			Primary Registration District No. <u>2001</u>		Registered No. <u>22</u>
City <u>Springfield</u> (NO. <u>2048</u> <u>W. Main</u> St. <u>7</u> Ward)			[If death occurred in a hospital or institution, give its NAME (instead of street and number)]		
FULL NAME <u>Jacques C. Boren</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>	DATE OF DEATH <u>Jan</u> <u>10</u> 19 <u>12</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Oct</u> <u>19</u> 19 <u>34</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Nov. 15</u> , 19 <u>11</u> , to <u>Jan 9</u> , 19 <u>12</u> , that I last saw him alive on <u>Jan 9</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at <u>10 P.M.</u>		
AGE <u>78</u> yrs. <u>2</u> mos. <u>21</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Acute of lungs.</u> <u>Pulmonary tuberculosis</u> <u>23A</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1000</u>			Contributory <u>None discovered</u> (Duration) <u>32</u> yrs. ___ mos. ___ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>			(Signed) <u>Wm. M. Smith</u> M. D. <u>Jan 10</u> , 19 <u>12</u> (Address) <u>Springfield, Mo.</u>		
PARENTS	NAME OF FATHER <u>Joseph Boren</u>		* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.		
	MAIDEN NAME OF MOTHER <u>Sarah Boren</u>		Where was disease contracted if not at place of death? Former or usual residence _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Illinois</u>		PLACE OF BURIAL OR REMOVAL <u>Croaker, Mo</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Adam C. Boren</u>			DATE OF BURIAL <u>Jan 12</u> 19 <u>12</u>		
(ADDRESS) <u>2048 W. Main St</u>			UNDERTAKER <u>W. J. Major</u>		
Filed <u>1/10</u> , 19 <u>12</u> <u>J. A. Lemmon</u> REGISTRAR			ADDRESS <u>City</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*, *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.)



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

County Greene Registration District No. 318 File No. 871
 Township _____ Primary Registration District No. 2001 Registered No. 22
 Village _____
 City Springfield (NO. 2048 N. Main St.: 7 Ward)

FULL NAME James C Boren

[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 wd
 WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Oct 19, 1834
 (Month) (Day) (Year)

AGE 78 yrs. 2 mos. 21 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)

BIRTHPLACE (City or town, State or foreign country) Tenn (Duration) 32 yrs. ___ mos. ___ ds.

PARENTS NAME OF FATHER Joseph Boren BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
 MAIDEN NAME OF MOTHER Parad (Unknown) BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 10, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 15, 1911, to Jan 9, 1912, that I last saw alive on Jan 9, 1912, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

Contributory none discovered (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Wm M Smith M. D. (Address) Springfield Mo
Jan 10, 1912

*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Adam C Boren X
 (ADDRESS) 2048 N. Main St

Filed X 1/10, 1912 J B Gimmion X
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Crocker Mo DATE OF BURIAL Jan 12, 1912
 UNDERTAKER W. J. Major ADDRESS City

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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