

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

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.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<u>Laclede</u>	Registration District No.	<u>923</u> File No. <u>1682</u>
Township or Village	<u>Spring Hollow</u>	Primary Registration District No.	<u>5613</u> Registered No. _____
City	<u>Lebanon</u> (No. _____ St.; _____ Ward)	(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME <u>William J. Jones</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Jan 17, 1912</u> (Month) (Day) (Year)
DATE OF BIRTH	I HEREBY CERTIFY, that I attended deceased from		
<u>May 17th, 1877</u> (Month) (Day) (Year)	<u>Jan 9, 1912, to Jan 17, 1912,</u>		
AGE	that I last saw him live on <u>Jan 15, 1912,</u>		
<u>84</u> yrs. <u>8</u> mos. <u>0</u> ds.	and that death occurred, on the date stated above, at <u>2³⁰</u> A. M.		
OCCUPATION	The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work <u>Farming</u>	<u>87A</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) _____	<u>Gr. Paralysis (Hemiplegic)</u>		
BIRTHPLACE	(Duration) <u>4</u> yrs. <u>5</u> mos. <u>17</u> ds.		
(City or town, State or foreign country) <u>Lafayette, Tenn.</u>	Contributory <u>Had recurrent strokes</u>		
NAME OF FATHER <u>Henry Jones</u>	(SECONDARY) <u>at subsequent intervals.</u>		
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn.</u>	(Duration) _____ yrs. _____ mos. _____ ds.		
MAIDEN NAME OF MOTHER <u>Nancy Jones</u>	(Signed) <u>S. S. Coasey</u> M. D.		
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</u>	<u>Jan 1912</u> (Address) <u>Lebanon, Mo.</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
(Informant) <u>Anna Barber</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
(ADDRESS) <u>Lebanon Mo</u>	At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
Filed <u>Jan 25, 1912</u>	Where was disease contracted if not at place of death? _____		
<u>Jan. B. Atchley</u> REGISTRAR	Former or usual residence _____		
	PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL	
	<u>Lebanon Mo</u>	<u>Jan 18, 1912</u>	
		ADDRESS	
		<u>X</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 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.)



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

PLACE OF DEATH

County Laclede
 Township Spring Hollow
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 933
 Primary Registration District No. 5613

File No. 1682
 Registered No. _____

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

FULL NAME William J. Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>May 17</u> , 18 <u>27</u> (Month) (Day) (Year)		
AGE <u>84</u> yrs. <u>8</u> mos. <u>8</u> ds.		(IF LESS than 1 day, ___ hrs. or ___ min.)
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 17, 1922
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 19, 1922, to Jan. 17, 1922, and that I last saw him alive on Jan. 15, 1922, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:
Paralysis (Hemiplegic)

BIRTHPLACE (City or town, State or foreign country) Lafayette Penn.

PARENTS	NAME OF FATHER <u>Henry Jones</u>	(Duration) <u>7</u> yrs. <u>5</u> mos. <u>17</u> ds.
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Penn.</u>	Contributory <u>Had recurrent strokes at subsequent intervals</u>
	MAIDEN NAME OF MOTHER <u>Raney Jones</u>	(Signed) <u>S. C. Casey</u> M. D. <u>Jan 1922</u> (Address) <u>Lebanon, Mo.</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Penn.</u>	*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Anna Barber
 (ADDRESS) Lebanon, Mo.

Filed Jan 25 - 1922
J. B. Pritchley
 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Oak Grove</u>	DATE OF BURIAL <u>Jan 18</u> 19 <u>22</u>
UNDERTAKER	ADDRESS

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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.)