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.

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

PLACE OF DEATH

County Lawrence

Township Ozark

or

Village

or

City (NO. St.: Ward)

Registration District No. 474 File No. 1757

Primary Registration District No. 5638 Registered No. 1

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

FULL NAME Isaac Jefferson West

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE American

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Nov. (Month) 17 (Day), 1819 (Year)

AGE 92 yrs. 1 mos. 18 ds.

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

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

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

BIRTHPLACE (City or town, State or foreign country) Tenn. 1-02

PARENTS

NAME OF FATHER Jefferson West

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

MAIDEN NAME OF MOTHER Not Known

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. West

(ADDRESS) Paris Springs Mo.

Filed Jan 6, 1912. L. J. Gum Morrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan (Month) 5 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20, 1911, to Jan 4, 1912, that I last saw him alive on Jan 4, 1912, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Lagrippe ~~and~~

5V

11B (Duration) ___ yrs. ___ mos. 25 ds.

Contributory (SECONDARY) Epithelioma S

(Duration) 25 yrs. ___ mos. ___ ds.

(Signed) S M Clark M. D.

Jan 6, 1911 (Address) Halltown 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 Simmons Cemetery

DATE OF BURIAL Jan 7, 1912

UNDERTAKER Will Morris

ADDRESS Miller Mo.

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, peritonaeum,* etc., *Carcinoma, Sarcoma,* 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.)

HUGH STEPHENS, JEFFERSON CITY.

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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

PLACE OF DEATH

County Lawrence

Township Ozark

or

Village

or

City (NO. St.: Ward)

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

Registration District No. 474 File No.

Primary Registration District No. 5638 Registered No. 1

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

FULL NAME Isaac Jefferson West

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov (Month) 17 (Day), 1819 (Year)

AGE: 92 yrs. 1 mos. 18 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): Penn

PARENTS
NAME OF FATHER: Jefferson West
BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn
MAIDEN NAME OF MOTHER: [illegible]
BIRTHPLACE OF MOTHER (City or town, State or foreign country): [illegible]

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. West

(ADDRESS) Paris Springs Mo

Filed March 14, 1912 Leona Hunt Morrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 5 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20, 1911, to Jan 4, 1912, that I last saw him alive on Jan 4, 1912, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lagrippe

(Duration) ___ yrs. ___ mos. 15 ds.

Contributory (SECONDARY) Epithelioma on face

(Duration) 20 yrs. ___ mos. ___ ds.

(Signed) S.M. Clark M. D.

3-13, 1912 (Address) Halltown 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: Kimmons Cem

DATE OF BURIAL: Jan 7, 1912

UNDERTAKER: Will Morris

ADDRESS: Miller Mo

SUPPLEMENTARY

JAN

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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