

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

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

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
County Waller
Township Saline Registration District No. 5-63 File No. 1994
Village _____ Primary Registration District No. 5-74-57B Registered No. 1
City _____ (NO. _____ St. _____ Ward _____)
FULL NAME Anna Wm Messick (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married (Write the word)
DATE OF BIRTH Nov 11, 1832 (Month) (Day) (Year)
AGE 79 yrs. 2 mos. 24 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) 1-62
BIRTHPLACE (City or town, State or foreign country) Delaware
PARENTS
NAME OF FATHER John W Messick
BIRTHPLACE OF FATHER (City or town, State or foreign country) Delaware
MAIDEN NAME OF MOTHER Nancy Fiddell
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Delaware
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Messick
(ADDRESS) Cham Wm
Filed Jan 7, 1912 REGISTRAR W. H. Allee

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 5, 1912 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h. _____ alive on _____, 191____,
and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows: Chronic Nephritis
13/1/12
(Duration) 2 yrs. _____ mos. _____ ds.
Contributory Diarrhea
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Allee M. D. (Address) Cham Wm
*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 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 Cham Wm DATE OF BURIAL Jan 7, 1912
UNDERTAKER J. H. Robertson ADDRESS Cham Wm

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

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

PLACE OF DEATH
County Miller
Township Saline
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 563 File No. 1994
Primary Registration District No. 5-755-B Registered No. 1

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

FULL NAME Ranuel Mino Messick

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Nov. 11, 1832
(Month) (Day) (Year)

AGE 79 yrs. 2 mos. 24 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) Delaware

PARENTS
NAME OF FATHER John Messick
BIRTHPLACE OF FATHER (City or town, State or foreign country) Delaware
MAIDEN NAME OF MOTHER Fancy Judell
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Delaware

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Messick
(ADDRESS) Cleau Mo.

Filed Jan 7 1927 by W. Allee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 5, 1927
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) 2 yrs. _____ mos. _____ ds.
Contributory Myrystrophy followed by retention of heart
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. Allee M. D. (Address) Cleau 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 Cleau Mo. DATE OF BURIAL Jan 7 1927
UNDERTAKER J. A. Robertson ADDRESS Cleau Mo.

Original file. date Jan 7 1927 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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