

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 Marion  
 Township Falouts Registration District No. 550 File No. 10143  
 or Village New Hope Primary Registration District No. 3743 Registered No. 8  
 or City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Calvin Johnston

**PERSONAL AND STATISTICAL PARTICULARS**

|   |  |   |
|---|--|---|
| SEX<br><u>Male</u>  | COLOR OR RACE<br><u>white</u>  | <del>SINGLE</del><br><del>MARRIED</del><br><del>WIDOWED</del><br><del>OR DIVORCED</del><br>(Write the word) |
| DATE OF BIRTH<br><u>March 11, 1831</u><br>(Month) (Day) (Year)  |  |   |
| AGE<br><u>81</u> yrs. <u>10</u> mos. <u>10</u> ds.  |  | IF LESS than<br>1 day, _____ hrs.<br>or _____ min.?   |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farmer</u> |  |   |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Ohio</u>  |  |   |
| PARENTS   | NAME OF FATHER<br><u>John Johnston</u>   |   |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Virginia</u> |   |
|   | MAIDEN NAME OF MOTHER<br><u>Hermana Widen</u>                                    |   |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Virginia</u> |   |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>B. G. Johnston</u><br>(ADDRESS) <u>Raymond</u>  |  |   |
| Filed <u>Mar 29 1912</u> of <u>B. M. Pike</u> REGISTRAR   |  |   |

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH March 21, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1912, to time of death, 1912, that I last saw him alive on March 12, 1912, and that death occurred, on the date stated above, at 8 am. The CAUSE OF DEATH\* was as follows:  
Paralytic X

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. B. Mason M. D. 1912 (Address) Mary Wood

\*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<br><u>Calvin Cemetery</u> | DATE OF BURIAL<br><u>3 23 1912</u> |
| UNDERTAKER<br><u>W. H. Lioch</u>                     | ADDRESS<br><u>Raymond</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*, *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, 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

PLACE OF DEATH

County Marion  
 Township Fabius  
 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. 550 File No. \_\_\_\_\_  
 Primary Registration District No. 5743 Registered No. 3

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

FULL NAME Calvin Johnston

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

|  |   |   |
|--|---|---|
| SEX<br><u>m</u>  | COLOR OR RACE<br><u>w</u>   | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word) |
| DATE OF BIRTH<br><u>Mar 11</u> , 1831<br>(Month) (Day) (Year)  |   |   |
| AGE<br><u>81</u> yrs. <u>10</u> mos. <u>10</u> ds.   |   | IF LESS than<br>1 day, ___ hrs. ___ min.<br>or ___ min.         |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>Fanner</u>                       |   |   |
| (b) General nature of industry, business, or establishment in which employed (or employer)<br><u>"</u> |   |   |
| BIRTHPLACE<br>(City or town, State or foreign country)   |   |   |
| PARENTS  | NAME OF FATHER<br><u>John Johnston</u>  |   |
|  | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country)<br><u>Va</u> |   |
|  | MAIDEN NAME OF MOTHER<br><u>Janice Wiseman</u>                                |   |
|  | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country)<br><u>Va</u> |   |

DATE OF DEATH Mar 21, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 1, 1912, to Mar 21, 1912  
 that I last saw h. alive on Mar 20, 1912  
 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH\* was as follows:  
Paralysis  
acute ascending

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

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

(Signed) J. C. Payne M. D.  
May 10, 1912 (Address) Maywood

\*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) R. C. Johnston  
 (ADDRESS) Maywood Mo.

Filed May 15, 1912 J. R. M. [Signature] REGISTRAR

PLACE OF BURIAL OR REMOVAL  
Johnston Co

DATE OF BURIAL  
3/23, 1912

UNDERTAKER  
W. H. Leach

ADDRESS  
Maywood

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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*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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