

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 Wells Madrid  
County Wells  
Township East  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 1014 File No. 33636  
Primary Registration District No. 5801 Registered No. \_\_\_\_\_

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

FULL NAME Robert J. Ward

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	
DATE OF BIRTH <u>May 5<sup>th</sup>, 1886</u> (Month) (Day) (Year)			
AGE <u>26</u> yrs. <u>5</u> mos. <u>19</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-574</u>			
BIRTHPLACE (City or town, State or foreign country) <u>Trinidad</u>			
PARENTS	NAME OF FATHER <u>John Thomas Ward</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Trinidad</u>		
	MAIDEN NAME OF MOTHER <u>Willie Flowers</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Trinidad</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>D B. Smith</u> (ADDRESS) <u>W. Keaton Mo</u> Filed <u>Oct 24</u> , 191 <u>2</u> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Oct 24</u> , 191 <u>2</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Oct 15</u> , 191 <u>2</u> , to <u>Oct 24</u> , 191 <u>2</u> , that I last saw him alive on <u>Oct 24</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>2 P.</u> m.	
The CAUSE OF DEATH* was as follows: <u>Pneumonia Lobar</u> <u>Complicated with</u> <u>Malaria 38</u> (Duration) <u>108</u> yrs. <u>1</u> mos. <u>12</u> ds.	
Contributory <u>Malaria</u> (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.	
(Signed) <u>P. M. Malvern</u> M. D. <u>Oct 24</u> , 191 <u>2</u> (Address) <u>W. Keaton</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.	
Where was disease contracted If not at place of death? Former or usual residence _____	
PLACE OF BURIAL OR REMOVAL <u>Wells</u>	DATE OF BURIAL <u>Oct 25</u> , 191 <u>2</u>
UNDERTAKER <u>H. J. Welch</u>	ADDRESS <u>W. Keaton Mo</u>

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 11-19-2010 BY 60322 UCBAW/STP

# 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, 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.)

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 New Madrid  
 Township East  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

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

BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Registration District No. 1014 File No. 33636 ✓  
 Primary Registration District No. 3801 Registered No. \_\_\_\_\_

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

FULL NAME Robert J. Ward

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDDED OR DIVORCED single  
(Write the word)

DATE OF BIRTH May 5, 1886  
(Month) (Day) (Year)

AGE 26 yrs. 5 mos. 19 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) \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 24, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 15, 1912 to Oct. 24, 1912, that I last saw him alive on Oct. 24, 1912, and that death occurred, on the date stated above, at 2 1/2 p.m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia lobar  
complicated with malaria

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 12 ds.

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

PARENTS

NAME OF FATHER	<u>John Thomas Ward</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country)	<u>Tenn.</u>
MAIDEN NAME OF MOTHER	<u>Willa Flowers</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<u>Tenn.</u>

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

(Signed) P. M. Malcolm M. D.  
Oct. 24, 1912 (Address) Rikeston, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. L. Ward  
 (ADDRESS) Rikeston, Mo.

Filed Dec 7 1912 by G. W. Hukey REGISTRAR

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
<u>Minnie Switch</u>	<u>Oct. 25, 1912</u>
UNDERTAKER	ADDRESS
<u>H. J. Welch</u>	<u>Rikeston, Mo.</u>

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[Approved by U. S. Consus 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 "*Asihenia*," "*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.)