

WHILE 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 McDonald
Township McMillin or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 518 File No. 36587
Primary Registration District No. 5694 Registered No. 55
FULL NAME David O. Sherwood
[If death occurred in a hospital or institution, give its NAME instead of street and number]

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>Jan 21, 1833</u> (Month) (Day) (Year) | | |
| AGE <u>79 yrs 10 mos ds.</u> | | 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) | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Leopold, Ind</u> | | |
| PARENTS | NAME OF FATHER <u>Jonathan Sherwood</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u> | |
| | MAIDEN NAME OF MOTHER <u>Kessiah Elrod</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u> | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>E. Sherwood</u> (ADDRESS) <u>Joplin Mo</u> | | |
| Filed <u>Nov 21, 1912</u> <u>Andrew Mitchell</u> REGISTRAR | | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Nov 20, 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 9 a.m.
The CAUSE OF DEATH* was as follows:
Old age
no physician in attendance
1 yr
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
(Address) _____

*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>Anderson Mo</u> | DATE OF BURIAL <u>Nov 21, 1912</u> |
| UNDERTAKER <u>Geo Patton Mc C Anderson Mo</u> | ADDRESS <u>Anderson Mo</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*, *peritonacum*, 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.)



WRITE PLAINLY, WITH UNFADING INK. FILE IN PLAIN ENGLISH.

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

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

County McDonald Registration District No. 518 File No. X

Township McMullin or Village _____ Primary Registration District No. 5694 Registered No. 6-6-

City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME David O. Sherwood

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--|---|---|---|--|
| SEX <u>M</u> | COLOR OR RACE <u>W</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u> | DATE OF DEATH <u>Nov 20</u> , 191 <u>2</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>Jan 21</u> , 18 <u>33</u> (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 <u>9 A.</u> m. | |
| AGE <u>79</u> yrs. <u>10</u> mos. <u>ds.</u> | | IF LESS than 1 day, _____ hrs. or _____ min.? | The CAUSE OF DEATH* was as follows: <u>Old age - No Physician in attendance</u> | |
| 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) _____ | | | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Laport Ind</u> | | | (Duration) <u>3</u> yrs. <u>6</u> mos. <u>ds.</u> | |
| PARENTS | NAME OF FATHER <u>Jonathan Sherwood</u> | | Contributory to old age (SECONDARY) (Duration) <u>3</u> yrs. <u>6</u> mos. <u>ds.</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>unk</u> | | (Signed) <u>W. D. Best</u> M. D. <u>Anderson Mo</u> 191 <u>2</u> (Address) <u>Anderson Mo</u> | |
| | MAIDEN NAME OF MOTHER <u>Kayal Elrod</u> | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unk.</u> | | 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) <u>E. Sherwood</u> | | | Where was disease contracted If not at place of death? _____ | |
| (ADDRESS) <u>Joplin Mo.</u> | | | Former or usual residence _____ | |
| Filed <u>Jan 15</u> , 191 <u>3</u> , <u>Andrew Tubbell</u> REGISTRAR | | | PLACE OF BURIAL OR REMOVAL <u>Anderson Mo</u> | |
| | | | DATE OF BURIAL <u>Nov 21</u> , 191 <u>2</u> | |
| | | | UNDERTAKER <u>Geo Tatum Mer Co Anderson Mo</u> | |
| | | | ADDRESS <u>Anderson Mo</u> | |

Original file, date _____, 19____ 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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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 "*Asithenia*," "*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.)

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