

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

PLACE OF DEATH

County Boone Co Mo

Township Cedar

Registration District No. 71

File No. 4233

Village _____

Primary Registration District No. 5710A

Registered No. 4

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Mosias H Jones

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 11, 1913
(Month) (Day) (Year)

DATE OF BIRTH Dec 28, 1889
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 4th, 1913, to Feb 10th, 1913, that I last saw him alive on Feb 10, 1913, and that death occurred, on the date stated above, at 4:20 a.m.

AGE 83 yrs. 1 mos. 14 ds. If LEBS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

45 E
162 old stroke
and Cancer
(Duration) 9 yrs. ___ mos. ___ ds.

(b) General nature of industry, business, or establishment in which employed (or employer) 1-0-0-0

BIRTHPLACE (City or town, State or foreign country) Boone Co Mo

Contributory (Secondary) (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Mosias Jones

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

MAIDEN NAME OF MOTHER Betsy Glenn

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

(Signed) H P Smith M. D.
Feb 11, 1913 (Address) Ashland 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

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

(Informant) H L Jones

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(ADDRESS) Ashland Mo

Where was disease contracted if not at place of death?

Filed Feb 12, 1913, A. J. Nichols REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL New Liberty DATE OF BURIAL Feb 13, 1913

UNDERTAKER H P Pauley & Sons ADDRESS Ashland Mo

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

PLACE OF DEATH

County _____
 Township _____ or Village _____ or City _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____
 (If death occurred in hospital or institution give its NAME inside of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (If fit the word)
DATE OF BIRTH _____	(Month) _____, 191____	(Day) _____, 191____ (Year)
AGE _____	_____ yrs. _____ mos. _____ ds.	if LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) _____		
NAME OF FATHER _____		
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		
MAIDEN NAME OF MOTHER _____		
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____ (Month) _____, 191____ (Day) _____, 191____ (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 _____ m. The CAUSE OF DEATH* was as follows:

Contributory _____ (SECONDARY)
 (Signed) _____, 191____ (Address) _____ M. D.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.

* 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, & RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ In the _____
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL _____, 191____

UNDERTAKER

ADDRESS _____

MISSOURI STATE BOARD OF HEALTH

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

CERTIFICATE OF DEATH

PLACE OF DEATH
 County Born Co mo
 Township Cedar
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 41 File No. _____
 Primary Registration District No. 5-110a Registered No. 4

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

FULL NAME Mosias H Jones

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec 28, 1829
 (Month) (Day) (Year)

AGE 83 yrs. 1 mos. 14 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmers
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Borne Co Mo

NAME OF FATHER Mosias Jones

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

MAIDEN NAME OF MOTHER Betsy Glenn

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) N. D. Jones

(ADDRESS) ashland mo

Filed Feb 12, 1913 by A. J. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH Feb 11, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 4, 1913, to Feb 10, 1913, that I last saw him alive on Feb 10, 1913, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
old age + cancer
right cheek
 (Duration) 0 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) M. R. Smith M.D. (Address) Ashland Mo
Feb 11, 1913

*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 New Liberty DATE OF BURIAL Feb 12, 1913

UNDERTAKER H. P. Paulry ADDRESS Ashland 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, 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 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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