

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

PLACE OF DEATH

County Clay  
Township Washington  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 198  
Primary Registration District No. 5278

File No. 4676  
Registered No. 29

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

FULL NAME J. A. Bailey

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH May 22, 1842  
(Month) (Day) (Year)

AGE 70 yrs. 9 mos. 22 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) Self

BIRTHPLACE (City or town, State or foreign country) N.Y.

NAME OF FATHER Simon Bailey

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

MAIDEN NAME OF MOTHER Do not know given name

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Bailey  
(ADDRESS) Holt MO

Filed February 26, 1913 J. N. Shouse REGISTRAR  
Sub

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 13, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 11, 1913, to Feb. 13, 1913, that I last saw him alive on Feb. 12, 1913, and that death occurred, on the date stated above, at 2:20 m.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia  
108  
(Duration) 0 yrs. 0 mos. 2 ds.

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

(Signed) Haynie Rowell M. D.  
Feb. 13, 1913 (Address) Kearney 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 New Hope DATE OF BURIAL Feb 14, 1913

UNDERTAKER L. Fry ADDRESS Holt Mo

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St.: \_\_\_\_\_ Ward) \_\_\_\_\_  
 (If death occurred in a hospital or institution give its NAME instead of street and number)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_ (If "rite" the word)  
 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (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 \_\_\_\_\_ (Month) \_\_\_\_\_ (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 \_\_\_\_\_.

The CAUSE OF DEATH\* was as follows:

\_\_\_\_\_, 191\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_

Contributory (SECONDARY)

\_\_\_\_\_, 191\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_

(Signed)

\_\_\_\_\_, 191\_\_\_\_ (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, at (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. 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 \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

PLACE OF DEATH

County Clay  
Township Washington  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 198 File No. \_\_\_\_\_  
Primary Registration District No. 0278 Registered No. 29

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

FULL NAME

J. A. Bailey

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 22, 1842  
(Month) (Day) (Year)

AGE 70 yrs. 9 mos. 22 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) N. Y.  
State or foreign country

NAME OF FATHER Simon Bailey

BIRTHPLACE OF FATHER Don't know

MAIDEN NAME OF MOTHER Mrs. Jones

BIRTHPLACE OF MOTHER Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. F. Bailey

(ADDRESS) Holt, Mo.

Filed Apr. 30, 1913 J. F. Bailey REGISTRAR

MEDICAL-CERTIFICATE OF DEATH

DATE OF DEATH Feb. 13, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 11, 1913, to Feb. 13, 1913, that I last saw him live on Feb. 12, 1913, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows: Lobar pneumonia

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

(Signed) Haynie Powell M. D.  
Feb. 13, 1913 (Address) Kearney 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 New Hope DATE OF BURIAL Feb. 14, 1913

UNDERTAKER L. Frey ADDRESS Holt, Mo.

Original file, date FEB. 13, 1913 All information called for must be written on this Supplementary Certificate

N. B. C. 1 Informants should be carefully supplied. AGE should be stated EXACTLY. Sex, may be properly classified. Extent of education of OCC.

# 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, 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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