

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

PLACE OF DEATH

County Dunklin

Township Union

or

Village _____

or

City _____

(NO. _____)

St. _____

Ward _____

Registration District No. 282

File No. 4832

Primary Registration District No. 5401

Registered No. 6

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

FULL NAME

John Brown Thomas

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 31, 1913
(Month) (Day) (Year)

DATE OF BIRTH Jan 20, 1972
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 31, 1913, to Jan 31, 1913, that I last saw him alive on Jan 31, 1913, and that death occurred, on the date stated above, at 10 P.m.

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

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

Congestion of Brain

87 A

BIRTHPLACE (City or town, State or foreign country) Campbell mo.

(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER John W. Thomas

Contributory (SECONDARY) _____

(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) John L. Brown M. D.
Feb 1, 1913 (Address) Campbell mo

MAIDEN NAME OF MOTHER Emma Thomas

*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) Hickston Mo

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

Where was disease contracted if not at place of death? _____

(Informant) John W. James

Former or usual residence _____

(ADDRESS) Hickston RFD

PLACE OF BURIAL OR REMOVAL 2nd Grove Cemetery DATE OF BURIAL Feb 1, 1913

Filed 75, 1913, L. W. Brewer REGISTRAR

UNDERTAKER One Bride Leo ADDRESS Campbell mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of...

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, meningitis, peritonaeum*, 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 "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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County DunklinTownship Union

or

Village _____

or

City _____ (NO. _____)

Registration District No. 282File No. 4832Primary Registration District No. 5401Registered No. 6

St. _____ Ward _____

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

FULL NAME John Brown James

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX mCOLOR OR RACE wSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF DEATH Jan 31, 1913

(Month)

(Day)

(Year)

DATE OF BIRTH Jan 20, 1913

(Month)

(Day)

(Year)

AGE _____

_____ yrs. _____ mos. 11 ds.If LESS than
1 day, _____ hrs
or _____ minI HEREBY CERTIFY, that I attended deceased from Jan 31, 1913, to Jan 31, 1913, that I last saw him alive on Jan 31, 1913, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Congestion of Brain
S. I. A.

(Duration) _____ yrs. _____ mos. _____ ds.

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) Campbell MoNAME OF FATHER John M. James

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

MAIDEN NAME OF MOTHER Angela ThomasBIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. James(ADDRESS) Campbell MoFiled Kys 1913 J. M. Brown REGISTRAR

Contributory _____

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John M. Brown M. D.71, 1913 (Address) Campbell 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

Campbell Mo

DATE OF BURIAL

Feb 1, 1913

UNDERTAKER

M. B. Bider & Co

ADDRESS

Campbell MoOriginal file date FEB 19 _____

All information called for must be written on this Supplementary Certificate.

N. B.—Every death certificate should be filed with the physician who attended the deceased. Physicians should state exactly the patient's condition at the time of death. If the patient was under the care of a physician, the name of the physician should be stated. If the patient was not under the care of a physician, the name of the person who attended the deceased should be stated. If the patient was under the care of a physician, the name of the physician should be stated. If the patient was not under the care of a physician, the name of the person who attended the deceased should be stated.

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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PLACE OF DEATH
County Dunklin
Township Union
or
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UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

Registration District No. 282 File No. 4832
Primary Registration District No. 0701 Registered No. 6
St. _____ Ward _____

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

FULL NAME John Brown Thomas James

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED
(If wife the word)

DATE OF BIRTH Jan 21, 1913
(Month) (Day) (Year)

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

DATE OF DEATH Jan 31, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Jan 31, 1913, to Jan 31, 1913,
that I last saw him alive on Jan 31, 1913,
and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Constriction of Brain
Probably Blood Clot
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory:
(Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John L. Brown M. D.
Feb 9, 1913 (Address) Campbell 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 Cedar Grove Cem DATE OF BURIAL Feb, 1913

UNDERTAKER V. McC. Beale ADDRESS Campbell mo

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) Campbell mo

NAME OF FATHER John W. James

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

MAIDEN NAME OF MOTHER Edna Thomas

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. James
(ADDRESS) Clariton R 153

Filed 2/5, 1913 W. Brown REGISTRAR

N. B.—Every item of information should be written in ink. If a copy is made, it should be made from the original. The original should be retained in the office of the registrar. The copy should be sent to the Bureau of Vital Statistics, Missouri State Board of Health, St. Louis, Mo.

Dr. John L. Brown Campbell Mo

Revised United States Standard Certificate of Death

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

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Continued on this Supplementary Certificate.