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.

NFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Nodaway

Township Nodaway

or Village

or City ~~Burlington Junct~~ (No. ____ St.; ____ Ward)

Registration District No. 618 File No. 6236-E

Primary Registration District No. 5820 Registered No. 1

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

FULL NAME James Graves

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Dec 13 (Month) (Day), 1851 (Year)

AGE: 61 yrs. 1 mos. 24 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, State or foreign country): Ross Co Ohio

PARENTS
- NAME OF FATHER: Joseph Graves
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Ross Co Ohio
- MAIDEN NAME OF MOTHER: Mary Ratliff
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos E Graves

(ADDRESS) Burlington Jct Mo

Filed Feb 7, 1913 Obed Dean REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 7 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1, 1913, to Feb 6, 1913, that I last saw h[illegible] alive on Feb 6, 1913; and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

107 R

(Duration) ____ yrs. ____ mos. 9 ds.

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W E Wallace M. D.

Feb 7, 1913 (Address) Burlington Jct. 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	DATE OF BURIAL
Ohio cemetery	Feb 9, 1913
UNDERTAKER	**ADDRESS**
T. E. Fordyce	Burlington Junct

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

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____
or
Village_____ Primary Registration District No._____ Registered No._____
or
City _____(NO._____, _____St.:_____Ward)

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

FULL NAME_____

WRITE 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.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, *I*_____
(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)

PARENTS

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) (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_____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory_____
(Secondary)

_____(Duration)_____yrs._____mos._____ds.

(Signed)_____ M. D.

_____, 191___ (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	DATE OF BURIAL
	_____, 191___
UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH INDELIBLE 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.

PLACE OF DEATH

County Jackson

Township 11

or

Village

or

City (NO. St.; Ward)

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

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

Registration District No. 618

Primary Registration District No. 5820

File No.

Registered No.

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

FULL NAME James Graves.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W.	Married

DATE OF BIRTH Satisfactory Information Supplied. (Month) (Day) 1 (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)

PARENTS

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)

Satisfactory Information Supplied.

SUPPLEMENTARY

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed Feb. 7, 1913 C. G. Dean, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 7, 1913 (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 ____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. E. Wallace M. D.

2/7, 1913 (Address) Burlington Jct.

*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	DATE OF BURIAL
	____, 191__
UNDERTAKER	ADDRESS

Original file, date Feb. 1913, 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]

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, 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 "*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.)

3-1920

Cancer
found