

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

PLACE OF DEATH  
County Ralls  
Township Saltriver  
or  
Village \_\_\_\_\_  
or  
City Perry (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 727 File No. 6488  
Primary Registration District No. 5959 Registered No. 6

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

FULL NAME John Powell Roach

PERSONAL AND STATISTICAL PARTICULARS

|  |  |   |
|--|--|---|
| SEX<br><u>Male</u>   | COLOR OR RACE<br><u>White</u>  | SINGLE MARRIED WIDOWED OR DIVORCED<br><u>Single</u><br>(Write the word) |
| DATE OF BIRTH<br><u>May 15, 1827</u><br>(Month) (Day) (Year)   |  |   |
| AGE<br><u>85</u> yrs. <u>8</u> mos. <u>22</u> ds.<br>IF LESS than 1 day, ____ hrs. or ____ min.?   |  |   |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)<br><u>1-0-2</u> |  |   |
| BIRTHPLACE<br>(City or town, State or foreign country)<br><u>Ohio</u>  |  |   |
| PARENTS  | NAME OF FATHER<br><u>Unknown</u>   |   |
|  | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country)<br><u>Unknown</u> |   |
|  | MAIDEN NAME OF MOTHER<br><u>Roach, A. Dunham</u>                                   |   |
|  | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country)<br><u>Unknown</u> |   |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 8, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 30, 1912, to Jan 23, 1913, that I last saw him alive on Jan 23, 1913, and that death occurred, on the date stated above, at 11 m. The CAUSE OF DEATH\* was as follows:  
Bright disease  
11 1/2  
137A  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Lakuffe  
(SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) John E. Brown M. D.  
Grace 1913 (Address) Perry, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. N. Roach

(ADDRESS) Perry, Mo

Filed 2/15 1913 C. M. Nease Deputy REGISTRAR

PLACE OF BURIAL OR REMOVAL Green Lawn Mo DATE OF BURIAL Feb 7, 1913  
UNDERTAKER Geo C Roach ADDRESS Perry Mo

MARGIN RESERVED FOR BINDING

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.

# 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 lung*, *meninges*, *peritoneum*, 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 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.)



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.

PLACE OF DEATH

County Ralls  
 Township Salt River  
 or  
 Village \_\_\_\_\_  
 or  
 City St. Louis (NO. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

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

CERTIFICATE OF DEATH 1

Registration District No. 727 File No. \_\_\_\_\_  
 Primary Registration District No. 5959 Registered No. 6

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

FULL NAME

John Powell Roach

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE white SINGLE MARRIED single WIDOWED wid OR DIVORCED wid (Write the word)

DATE OF BIRTH May 15, 1827  
 (Month) (Day) (Year)

AGE 85 yrs. 8 mos. 23 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) Ohio

PARENTS  
 NAME OF FATHER unk  
 BIRTHPLACE OF FATHER \_\_\_\_\_  
 MAIDEN NAME OF MOTHER Rose A. Durham  
 BIRTHPLACE OF MOTHER unk

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) E. N. Roach  
 (ADDRESS) Cerry Mo

Filed Feb 9 x, 1913 C. C. Rose REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 8, 1913  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 30, 1913 to Jan 23, 1913, that I last saw h alive on Jan 23, 1913, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:  
Bright's Disease

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

(Signed) J. J. Moore M. D.  
Feb 9, 1913 (Address) Cerry 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 Green Lawn Mo DATE OF BURIAL Feb 9, 1913  
 UNDERTAKER Geo C. Rose ADDRESS Cerry Mo

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*, *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.)

2870

WRITE PLAINLY, WITH UNFADING INK—THIS IS A F

N. B.—Every item of information should be carefully spelled. AGE should be stated in plain terms, so that it may be properly clear. Exact

ICJ 11-1-1916

1 PLACE OF DEATH

County Palls  
Township Saltrier  
Village \_\_\_\_\_  
City Perry (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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.  
Registration District No. 727 File No. 6488  
Primary Registration District No. 5959 Registered No. 6

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

PERSONAL AND STATISTICAL PARTICULARS

|  |   |  |
|--|---|--|
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                                     | 5 SINGLE MARRIED WIDOWED OR DIVORCED<br><u>married</u><br>(Write the word) |
| 6 DATE OF BIRTH<br><u>May 15</u> , 19 <u>17</u><br>(Month) (Day) (Year)  |   |  |
| 7 AGE<br><u>85</u> yrs. <u>8</u> mos. <u>23</u> ds.  |   | If LESS than 1 day... hrs. or min.?  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry business, or establishment in which employed (or employer) |   |  |
| 9 BIRTHPLACE<br>(City or town, State or foreign country)   |   |  |
| PARENTS  | 10 NAME OF FATHER   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) |  |
|  | 12 MAIDEN NAME OF MOTHER  |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) |  |

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Feb 8, 1913  
(Month) (Day) (Year)

17 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) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) \_\_\_\_\_ M. D. \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospital, Institutions, Transients, or Recent Residents)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) E. N. Roach  
(Address) Perry Mo

15 Filed June 5<sup>th</sup> 1917 J. Walter Registrar

# Revised United States Standard Certificate of Death

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

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*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), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "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.)