

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.

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

8064

PLACE OF DEATH
County Bates
Township Halmit
or
Village
or
City

Registration District No. 56 File No. [REDACTED]
Primary Registration District No. 5087 Registered No. 2
City (NO. _____) St. _____ Ward _____

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

FULL NAME Joseph Hess

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 9 12, 1824
(Month) (Day) (Year)

AGE 88 yrs. 5 mos. 26 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) 1-0-2-1-130

BIRTHPLACE (City or town, State or foreign country) Ohio 129 162

PARENTS
NAME OF FATHER David Hess
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. S. Hess

(ADDRESS) 711 Home mo
R. H. St.

Filed Mar 9, 1913 H. G. Rhoades M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Mar 6, 1913, to Mar 8, 1913, that I last saw him alive on Mar 6, 1913, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:
Peritonitis caused by
slight disturbance
of bowels
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Senility
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H. A. Rhoades M. D.
Mar 9, 1913 (Address) Foster 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 Home Cemetery DATE OF BURIAL Mar 9, 1913

UNDERTAKER R. H. McConnell ADDRESS Home 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*, *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*, *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.)



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

PLACE OF DEATH

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

Township Walnut Registration District No. 56 File No. _____

Village _____ Primary Registration District No. 5087 Registered No. 2

City _____ No. _____ St. _____ Ward _____

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

FULL NAME

Joseph Hess

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar. 8, 1913
(Month) (Day) (Year)

DATE OF BIRTH 9 12, 1824
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 6, 1913, to Mar 8, 1913,
that I last saw him alive on Mar 6, 1913,
and that death occurred, on the date stated above, at 1 p. m.

AGE 88 yrs. 5 mos. 26 ds. IF LESS than 1 day, ___ hrs or ___ min.

The CAUSE OF DEATH* was as follows:
Peritonitis following a slight attack of dysentery

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

(Duration) ___ yrs. ___ mos. 4 ds.
Contributory senility
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Ohio

NAME OF FATHER David Hess

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

MAIDEN NAME OF MOTHER Don't know

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

(Signed) H. A. Rhoades M. D.
Mar 9, 1913 (Address) Foster, 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. S. Hess

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) Home, Mo. R. 7 #2

PLACE OF BURIAL OR REMOVAL Home Cemetery DATE OF BURIAL Mar. 9, 1913

Filed Mar 9 & 1913 H. A. Rhoades REGISTRAR

UNDERTAKER H. W. McConnell ADDRESS Home, Mo.

Revised United States Standard Certificate of Death

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

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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," "Anacmia" (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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