

PLACE OF DEATH

County

Benton

Township

Nuly

Registration District No.

88

File No.

8281

Village

Primary Registration District No.

5780

Registered No.

8

City

(NO. _____)

St.; _____

Ward) _____

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

FULL NAME

James Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

*Negro*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Married*

DATE OF BIRTH

*Nov**4, 1884*

(Month)

(Day)

(Year)

AGE

28 yrs. *4* mos. *12* ds.If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

21-02

BIRTHPLACE

(City or town, State or foreign country)

Miss

NAME OF FATHER

*Sam Johnson*BIRTHPLACE OF FATHER
(City or town, State or foreign country)*Miss*

MAIDEN NAME OF MOTHER

*Matilda ward*BIRTHPLACE OF MOTHER
(City or town, State or foreign country)*Miss*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William ward*

(ADDRESS)

Nulyville Mo

Filed

*Nov 15, 1912**W. B. Davis*

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

*Nov**16, 1912*

(Month)

(Day)

(Year)

HEREBY CERTIFY, that I attended deceased from

*Nov 15, 1912, to Nov 15, 1912,*that I last saw him alive on *Nov 10, 1912,*and that death occurred, on the date stated above, at *12 P. m.*

The CAUSE OF DEATH* was as follows:

*Pneumonia Labor**108*

(Duration)

yrs.

mos. *10*

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed) *W. B. Davis*

M. D.

(Address) *Nulyville 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

Miss

DATE OF BURIAL

1912

UNDERTAKER

A. W. Green

ADDRESS

Poplar Bluff Mo

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 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.)

MAY 10 1946

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

PLACE OF DEATH
 County Butler
 Township Muly
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

Registration District No. 88 File No. _____Primary Registration District No. 5130 Registered No. 8

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

FULL NAME James Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 16, 1913
 (Month) (Day) (Year)

DATE OF BIRTH Nov 4, 1884
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 5, 1913, to Mar 15, 1913, that I last saw him alive on Mar 15, 1913, and that death occurred, on the date stated above, at _____ m.

AGE 38 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:

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

Pneumonia Lobar
 (Duration) _____ yrs. _____ mos. 10 ds.

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. B. Davis M. D.
 _____ 1913 (Address) Muly Mo

PARENTS
 NAME OF FATHER Sam Johnson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Miss
 MAIDEN NAME OF MOTHER Maude Ward
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Miss

*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

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

(Informant) Wm Ward
 (ADDRESS) Mulyville Mo

Former or usual residence _____

Filed Mar 19, 1913, W. B. Davis REGISTRAR

PLACE OF BURIAL OR REMOVAL Miss DATE OF BURIAL Wetmore

UNDERTAKER A. W. Lewis ADDRESS Coplar Shuffo

MAR 1913

Revised United States Standard Certificate of Death

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

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