

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 Jasper
 Township Madison
 or
 Village _____
 or
 City Carthage (NO. East Chestnut St.; _____ Ward)

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

Registration District No. 408 File No. 9491
 Primary Registration District No. 5374 Registered No. 33

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

FULL NAME John Addison Carter

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH September 29, 1833
 (Month) (Day) (Year)

AGE 79 yrs. 5 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Oak Hill, Pa.

PARENTS
 NAME OF FATHER John Carter
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Berks Co., Pa.
 MAIDEN NAME OF MOTHER Sarah Wiley
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lancaster Co., Pa.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. Carter
 (ADDRESS) Carthage, Mo.

Filed Mar 9, 1913, James B. Lund REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 7, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 24, 1913, to March 7, 1913, that I last saw him alive on March 7, 1913, and that death occurred, on the date stated above, at 7:42 p.m.

The CAUSE OF DEATH* was as follows:
La. Grippe complicated with blood poisoning

Contributory Blood poisoning (SECONDARY) (Duration) one yrs. — mos. — ds.

(Signed) J. B. Thomas M. D.
March 8, 1913 (Address) Carthage, 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 Oak Hill DATE OF BURIAL 3/9, 1913

UNDERTAKER Wichart ADDRESS Carthage

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

PLACE OF DEATH

County _____
 Township _____ or Village _____ or City _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____
 City _____ (NO. _____)
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
 SINGLE MARRIED WIDOWED OR DIVORCED (If rise the word)

DATE OF BIRTH _____ (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) _____

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) _____

DATE OF DEATH _____ (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:

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ 191____ (Address) _____ M. D.

*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 _____

Filed _____ 191____ REGISTRAR _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED EXCEPT WHERE SHOWN OTHERWISE

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.

Dr. J. B. Thomas Carthage Mo

PLACE OF DEATH

County Gasper

Township _____

or Village _____

or City _____

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. _____

File No. 9491

Primary Registration District No. _____

Registered No. _____

(NO. _____) St.: _____ Ward _____

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

FULL NAME John Addison Carter

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (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 _____, 1913 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1913 (Month) 3 (Day) 7 (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: Grippe complicated with blood poisoning
Wraemide
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Blood poisoning
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. B. Thomas M. D.
June 5, 1913 (Address) Carthage 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 _____, 191____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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); *Megsles*;

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.)