

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

PLACE OF DEATH  
County Lewis ✓  
Township Deer  
or  
Village  
or  
City Lalrange Mo. (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 480 File No. 9754  
Primary Registration District No. 4289 Registered No. 13

FULL NAME Jacob P Cook

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>	DATE OF DEATH <u>3</u> <u>March 11<sup>th</sup></u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>May 14</u> , 18 <u>38</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>March 8</u> , 191 <u>3</u> , to <u>Mar 10</u> , 191 <u>3</u> , that I last saw him alive on <u>Mar 10<sup>th</sup></u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>7 P.</u> m.	
AGE <u>74</u> yrs. <u>10</u> mos. <u>7</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Paralysis</u> <u>870</u> <u>11 B</u> (Duration) ___ yrs. ___ mos. <u>4</u> ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>			Contributory <u>La Grange Mo</u> (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. (Signed) <u>M. O. Owens</u> M. D. <u>Mar 12<sup>th</sup></u> , 191 <u>3</u> (Address) <u>La Grange Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>William Cook</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Doit-Know</u>		Where was disease contracted if not at place of death? _____	
	MAIDEN NAME OF MOTHER <u>Doit-Know</u>		Former or usual residence _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Doit-Know</u>		PLACE OF BURIAL OR REMOVAL <u>Lalrange Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nellie Cook</u>			DATE OF BURIAL <u>Mar 13</u> , 191 <u>3</u>	
(ADDRESS) <u>Lalrange Mo</u>			UNDERTAKER <u>Leucht Sanders</u>	
Filed <u>Mar 12</u> , 191 <u>3</u> , <u>M. S. Zilly</u> REGISTRAR			ADDRESS <u>Lalrange Mo</u>	

# 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.)



WRITE PLAINLY, WITH UNF. K. TH. A PERMANENT RECORD

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

PLACE OF DEATH

County Lewis

Township \_\_\_\_\_

Village \_\_\_\_\_

City La Grange (NO. \_\_\_\_\_)

Registration District No. 480

Primary Registration District No. 4289

File No. \_\_\_\_\_

Registered No. 13

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

FULL NAME

Jacob P. Cook

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) w.

DATE OF BIRTH May 4, 1838  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than day, hrs. \_\_\_\_\_ 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) Satisfactory information supplied

Filed March 1913 W. S. H. H. H. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 11, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 8, 1913, to Mar. 10, 1913, that I last saw him alive on 11 10, 1913, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:  
Paralysis  
Caused by Cerebral Haemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

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

(Signed) W. O. Owens M. D.  
March 12, 1913 (Address) La Grange 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 \_\_\_\_\_ 1913

UNDERTAKER Satisfactory ADDRESS \_\_\_\_\_

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