

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

File No. **10378**

County Ralls Co Registration District No. 724 Township Depeuor Primary Registration District No. 5567 Registered No. 5

City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

**FULL NAME** James W. Ellis

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>single</u>	DATE OF DEATH <u>March 19</u> , 191 <u>3</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Nov 2</u> , 18 <u>41</u> (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Feb 12</u> , 191 <u>3</u> , to <u>March 19</u> , 191 <u>3</u> , that I last saw him alive on <u>March 19</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>9 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Anemia</u> <u>131</u> <u>139) B</u>		
AGE <u>71</u> yrs. <u>6</u> mos. <u>11</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?					
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-0-2</u>			Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.  (Signed) <u>Tom B. Norton</u> M. D. <u>3/20</u> , 191 <u>3</u> (Address) <u>Center Mo</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Ralls Co Mo</u>					
NAME OF FATHER <u>L. V. Ellis</u>			*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 _____		
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>					
MAIDEN NAME OF MOTHER <u>Elisabeth Jeffers</u>					
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>					
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>H. M. Ellis</u> (ADDRESS) <u>Center Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Salem Country</u> DATE OF BURIAL <u>March 20</u> , 191 <u>3</u>		
15 Filed <u>3/22</u> , 191 <u>3</u> , <u>J. J. Francis</u> REGISTRAR			UNDEERTAKER <u>J. D. Nourse</u> ADDRESS <u>Center Mo</u>		

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
JEFFERSON CITY, MISSOURI

N. B.—Every CAUSE OF DEATH

PLACE OF DEATH

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

County \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME

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) \_\_\_\_\_

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 \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_

I HEREBY CERTIFY, that I attende \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_ that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred, on the date stated at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ (Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or H LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTO RECENT RESIDENTS) \_\_\_\_\_ in the At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ Where was disease contracted if not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE O \_\_\_\_\_

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

Revised United States Standard Certificate of Death

U.S. Census and American Public Health

MARGIN RESERVED FOR OTHERS

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

CAUTION: Informant must be at least 18 years of age, sane, sober, and of legal age. Informant should state name, address, and relationship to deceased. Informant should state name, address, and relationship to deceased.

PLACE OF DEATH

County Ralls  
Township Spencer  
or  
Village  
or  
City (NO. \_\_\_\_\_) \_\_\_\_\_

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. 726 File No. \_\_\_\_\_  
Primary Registration District No. 5957 Registered No. 7  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

James W. Ellis

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

DATE OF BIRTH Nov - 2, 1841  
(Month) (Day) (Year)

AGE 71 yrs. 6 mos. 18 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)

BIRTHPLACE (City or town, State or foreign country) Ralls, Mo.

PARENTS NAME OF FATHER J. W. Ellis

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

MAIDEN NAME OF MOTHER Elizabeth Jeffers

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. W. Ellis  
(ADDRESS) Center Mo.

Filed 3/22 1913 REGISTRAR J. D. Stulze

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 18, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 12, 1913, to March 19, 1913  
that I last saw him alive on March 19, 1913

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Uræmia  
(Duration) \_\_\_ yrs. \_\_\_ mo. \_\_\_ ds.

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mo. \_\_\_ ds.

(Signed) M. P. Perry M. D. 3/20 1913 (Address) Center 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 Salmon Cem. DATE OF BURIAL March 20 1913

UNDERTAKER J. D. Stulze ADDRESS Center Mo.

# Revised United States Standard Certificate of Death

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

10378

**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, 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), 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.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, 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 Waller  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

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

Registration District No. \_\_\_\_\_ File No. 10378  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

FULL NAME James W. Ellis

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH		_____, 191____, to _____, 191____, (Month) (Day) (Year)	
AGE		_____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hr. 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)		

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH 3/18, 1913  
 (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:  
Crainia  
Chronic Suppuration

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

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

(Signed) Henry B. Koster M. D.  
 \_\_\_\_\_, 191\_\_\_\_ (Address) Center St

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

SUPPLEMENTARY

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_  
 Filed \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_  
 REGISTRAR

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
_____	_____

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]

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**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," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichoemia," "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.)