

PLACE OF DEATH

County CamdenTownship Warren

Village _____

City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH **12396**File No. 3 **12391**Registration District No. 121Primary Registration District No. 5173

Registered No. _____

FULL NAME

Albert Caviness

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)DATE OF BIRTH Oct 19, 1837
(Month) (Day) (Year)AGE: 77 yrs. 5 mos. 9 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) 1-02BIRTHPLACE (City or town, State or foreign country) North CarolinaPARENTS NAME OF FATHER Albert CavinessBIRTHPLACE OF FATHER (City or town, State or foreign country) UnknownMAIDEN NAME OF MOTHER Sarka MosierBIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Caviness(ADDRESS) LeicestervilleFiled 11-28-13 Crystal Clairborn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 29, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov 20, 1913, to Nov 29, 1913, that I last saw him alive on Nov 28, 1913, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
131
(Duration) 4 yrs. _____ mos. _____ ds.Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) E. O. Leiberman M. D.13-29-1913 (Address) Leicesterville

* 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 Plot DATE OF BURIAL Nov 30, 1913UNDERTAKER None ADDRESS None

ING NK—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.

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.)



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

PLACE OF DEATH

County Warren
Township Warren
or
Village _____
or
City _____ (No. _____) St. _____ Ward _____

Registration District No. 121 File No. _____
Primary Registration District No. 5173 Registered No. 3

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

FULL NAME Albert Coviness

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE w SINGLE widow
MARRIED
OR DIVORCED
(# write the word)

DATE OF DEATH 3/29, 1913
(Month) (Day) (Year)

DATE OF BIRTH Oct. 19, 1837
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3/29, 1913 to 3/29, 1913, that he was last seen alive on 3/29, 1913, and that death occurred, on the date stated above, at 10 a.m.

AGE 77 yrs. 5 mos. 9 ds. if LESS than 1 day, _____ hr. or _____ min?

CAUSE OF DEATH* was as follows:
Leucemia cut. nephritis

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

(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) North Carolina

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER Albert Coviness

(Signed) E. E. Claborn M. D. (Address) Deatonsville

BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know

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

MAIDEN NAME OF MOTHER Wanda Mosier

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 MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Albert Coviness

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

(ADDRESS) Deatonsville

PLACE OF BURIAL OR REMOVAL Home DATE OF BURIAL 3/25, 1913

Filed Mar. 9, 1913 Hospital REGISTRAR

UNDERTAKER Winn ADDRESS _____

APR 1913

All information called for must be written on this Supplementary Certificate.

Original file date: _____

WRITE PLAINLY, WITH UNFADING INK. Do not use red ink. Do not use blue ink. Do not use green ink. Do not use purple ink. Do not use black ink. Do not use white ink. Do not use yellow ink. Do not use orange ink. Do not use pink ink. Do not use brown ink. Do not use grey ink. Do not use light blue ink. Do not use light green ink. Do not use light purple ink. Do not use light brown ink. Do not use light grey ink. Do not use light blue ink. Do not use light green ink. Do not use light purple ink. Do not use light brown ink. Do not use light grey ink.

REGISTRARS SHOULD BE SPECIALLY QUALIFIED. PHYSICIANS SHOULD STATE EXACTLY THE CAUSE OF DEATH. EXACT STATEMENT OF OCCASION IS VERY IMPORTANT.

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," "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.)