

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Dunklin

Township _____

Registration District No. 282File No. 12650or Village CampbellPrimary Registration District No. 4166Registered No. 33

or City _____ (NO. _____)

St.: _____ Ward: _____

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

FULL NAME William Charlie Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Feb 2, 1882</u> (Month) (Day) (Year)		
AGE <u>31</u> yrs. <u>1</u> mos. <u>3</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		

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

BIRTHPLACE
(City or town, State or foreign country) 3-07 MissouriPARENTS
NAME OF FATHER James JonesBIRTHPLACE OF FATHER
(City or town, State or foreign country) TennesseeMAIDEN NAME OF MOTHER Aley DyeBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Jones(ADDRESS) Campbell MoFiled 4/3, 1913, L. W. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 5, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 23, 1913, to May 5, 1913, that I last saw him alive on May 5, 1913, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
207M
109A
(Duration) ___ yrs. ___ mos. 12 ds.

Contributory by exposure on Rail Road
(SECONDARY) (Duration) ___ yrs. ___ mos. 12 ds.
(Signed) P. J. Keating M. D.
apt 7, 1913 (Address) Campbell 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 Nalcomb Mo DATE OF BURIAL 5/6, 1913UNDERTAKER O. McQuade ADDRESS Campbell Mo

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Reubelin

Township _____

or Village _____

or City Campbell (NO. _____)

Registration District No. 282 File No. _____

Primary Registration District No. 4166 Registered No. 33

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

FULL NAME

Wm Chas. Jones

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
DATE OF BIRTH <u>2/2</u> (Month) <u>1888</u> (Year)		
AGE <u>31</u> yrs. <u>6</u> mos. <u>3</u> ds.		

DATE OF DEATH
3/5 (Month) 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1913, to _____, 1913, that I last saw him alive on 3/5, 1913, and that death occurred, on the date stated above, at 11 a. m.

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

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

The CAUSE OF DEATH* was as follows:
Pneumonia
injury received on R.R.
Pneumonia was specific cause of death
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory injury received lifting hand car
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) T. J. [unclear] M. D.
May 5, 1913 (Address) Campbell Mo

BIRTHPLACE
(City or town, State or foreign country)
Mo. [unclear]

PARENTS

NAME OF FATHER <u>James Jones</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>[unclear]</u>
MAIDEN NAME OF MOTHER <u>Esther [unclear]</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>[unclear]</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. State _____ yrs. _____ mos. _____ ds.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Jones
Campbell
(ADDRESS)

PLACE OF BURIAL OR REMOVAL <u>Halcomb Mo.</u>	DATE OF BURIAL <u>3/6</u> 191 <u>3</u>
UNDERTAKER <u>Wm C. Brude</u>	ADDRESS <u>Campbell Mo</u>

Filed [unclear] 1913
REGISTRAR W. B. [unclear]

APR 1913

V. B. B.—Every item of information should be carefully and correctly classified. Exact statement of OCCUPATION is very important.

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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.), "Dropy," "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.)