

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.

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

PLACE OF DEATH Newton County BY Foster
 Township _____ or Village Neashe or City _____ (NO. _____) St. _____ Ward _____
 Registration District No. 609 File No. 17221
 Primary Registration District No. 4363 Registered No. 40
 FULL NAME John Franklin Hoque [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 Married
 DATE OF BIRTH July 16th, 1895
 (Month) (Day) (Year)
 AGE 78 yrs. 2 mos. 20 ds. If LESS than 1 day, _____ hrs. or _____ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work 1953 Nephritis
 (b) General nature of industry, business, or establishment in which employed (or employer) 5-01 13 10 2 Organic Home Trade
 BIRTHPLACE (City or town, State or foreign country) Met Va
 NAME OF FATHER Dont know
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont know
 MAIDEN NAME OF MOTHER Dont know
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 8th, 1933
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 1912, to _____, 1913,
 that I last saw him alive on 6/8, 1913,
 and that death occurred, on the date stated above, at 8 m.
 The CAUSE OF DEATH* was as follows:
1953 Nephritis
Organic Home Trade
 (Duration) 1 yrs. _____ mos. _____ ds.
 Contributory Legs
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) H F Foster M. D.
5/13, 1913 (Address) Neashe Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Hoque
 (ADDRESS) Neashe Mo
 Filled May 13, 1913, W R Waters REGISTRAR

*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 1007 Cemetery DATE OF BURIAL May 9, 1913
 UNDERTAKER J R Bigham Co ADDRESS Neashe Mo

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*, *peritonaeum*, 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.

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

PLACE OF DEATH
County Newton
Township _____
Village _____
City Neosho (NO. _____) St.: _____ Ward _____

Registration District No. 609 File No. _____
Primary Registration District No. 4363 Registered No. 40

FULL NAME John Franklin Hogue

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____ SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____
Satisfactory information supplied.

DATE OF DEATH May 8, 1913
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)
Satisfactory information supplied.

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above _____ m. The CAUSE OF DEATH* was as follows:

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ min. _____ sec. Satisfactory information supplied.

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employee) House carpenter

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) Hellie Hogue
(ADDRESS) Neosho, Mo.

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

*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 REGENT 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 _____

Filed July 9 1913 Wm Rosebery REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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