

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

PLACE OF DEATH
 County Lentz
 Township Howard or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
 Registration District No. 309 File No. 29549
 Primary Registration District No. 5434 Registered No. 54

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

FULL NAME James H. Stephenson

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>married</u>	DATE OF DEATH <u>Sept 1st</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>April 28</u> , 18 <u>82</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Aug 15th</u> , 191 <u>3</u> , to <u>Sept Aug 31st</u> , 191 <u>3</u> , that I last saw him alive on <u>Aug 31st</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>8:20 a.m.</u>	
AGE <u>61</u> yrs. <u>5</u> mos. <u>4</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>apoplexy</u> <u>1948</u> <u>26</u> <u>36</u> (Duration) ___ yrs. ___ mos. <u>5</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)			Contributory <u>septicemia</u> (SECONDARY) (Duration) ___ yrs. ___ mos. <u>10</u> ds. (Signed) <u>W. S. Campbell</u> M. D. <u>Sept 1st</u> , 191 <u>3</u> (Address) <u>Albany, Mo.</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Lentz Co. Mo.</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>Wm. Stephenson</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>Ken.</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER <u>Smith</u>		PLACE OF BURIAL OR REMOVAL <u>Corvick Kansas</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Alabama</u>		DATE OF BURIAL <u>Sept 4</u> , 191 <u>3</u> ADDRESS <u>Albany Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. J. H. Stephenson</u> (ADDRESS) <u>Corvick Kansas</u>			FILED <u>Sept. 1</u> , 191 <u>3</u> <u>W. T. Martin</u> REGISTRAR	

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, 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.)



A PERMANENT RECORD

10 1

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PLACE OF DEATH

County Gentry
Township Howard
Village _____
City _____ (NO. _____ St.: _____ Ward _____)

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. 309 File No. _____
Primary Registration District No. 5434 Registered No. 54

FULL NAME

James H. Stephenson.

[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 OR DIVORCED married
(Write the word)

DATE OF BIRTH Satisfactory Information Supplied
(Month) _____ (Day) 1 (Year) _____

AGE _____ yrs. _____ mos. _____ ds. IF LESS than _____ 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) _____

PARENTS NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X
(ADDRESS) Norwich, Kans

Filed Sept. 1, 1913 REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 1, 1913
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____
that I last saw h _____ alive on _____, 191____, to _____, 191____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) _____ yrs. _____ mos. 5 ds.
Contributory Septicemia
(SECONDARY) from an infected wound on heel
(Duration) _____ yrs. _____ mos. _____ ds.

Signed) X W S Campbell X
Sept. 1, 1913 (Address) Albany, 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 Satisfactory Information Supplied DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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