

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

PLACE OF DEATH
County Miss. Co.

Township _____
or
Village Charleston
or
City _____ (NO. _____) St. _____ Ward _____

Registration District No. 566
Primary Registration District No. 3030

File No. 5444
Registered No. 9

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

FULL NAME John D. Boman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Wht SINGLE Married
MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Jan 24th, 1844
(Month) (Day) (Year)
AGE 77 yrs. - 10 mos. - 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER J. Boman
BIRTHPLACE OF FATHER Ky
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Do not know
BIRTHPLACE OF MOTHER Do not know
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Boman (20)
(ADDRESS) Charleston Mo

Filed 2-4-1914 A. H. Gray
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 3, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1914, to Feb 3, 1914, that I last saw him alive on Feb 3, 1914, and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:
Brain softening
186A
82C
about
(Duration) 1 yrs. 3 mos. - 0 ds.
Contributory Injury to old ununited fracture of R. femur
(Duration) 7 yrs. - 0 mos. - 0 ds.

(Signed) John L. Boone M. D.
Feb 4, 1914 (Address) Charleston 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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Oak Grove DATE OF BURIAL 2-5-1914
UNDERTAKER W. H. Co. ADDRESS Charleston Mo.

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*, *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 septicæmia," "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.)

PLACE OF DEATH
County Mississippi
Township _____
or
Village Charleston
or
City _____ (NO. _____ St.: _____ Ward _____)

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

CERTIFICATE OF DEATH
Registration District No. 566 File No. _____
Primary Registration District No. 3030 Registered No. 9

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

FULL NAME Joseph H. S. Roman

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

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

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

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) _____

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

(ADDRESS) _____

Filed Feb. 25 1914 J. R. G.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 3 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1914, that I last saw him alive on _____, 1914, and that death occurred, on the date stated above. The CAUSE OF DEATH* was as follows:

Brain Softening
Don't know cause.
(Duration) 1 yrs. 3 mos. 11 ds.

Contributory Injury to old wound fracture of right femur
(Signed) John B. Rome M.D.
2 E. H. 1914 (Address) Charleston, W. Va.

*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 _____ DATE OF BURIAL _____ 1914

UNDERTAKER _____
Satisfactory Information Supplied

SUPPLEMENTARY

Every item of information should be stated in plain terms, so that it may be understood by all. Statement of OCCUPATION is very important.

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