MARGIN RESERVED FOR BINDING

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

8921

PLACE OF DEATH

County: Jasper

Township or Village or City: ~~Jasper~~ Prosperity

Registration District No. 414 — File No.

Primary Registration District No. 4246 — Registered No. 8

(NO. ____ St.: ____ Ward)

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

FULL NAME Everett Alfiam Cowdry

PERSONAL AND STATISTICAL PARTICULARS

SEX: Boy

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Child

DATE OF BIRTH: ~~Feb~~ March 24, 1913 (Month) (Day) (Year)

AGE: ____ yrs. 13 mos. 14 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Prosperity

PARENTS
NAME OF FATHER: Josephett Cowdry
BIRTHPLACE OF FATHER (City or town, State or foreign country): [illegible]
MAIDEN NAME OF MOTHER: Lula [illegible]
BIRTHPLACE OF MOTHER (City or town, State or foreign country): [illegible]

THE ABOVE IS TRUE TO THE BEST OF [illegible]WLEDGE

(Informant) H. W. Sh[illegible]

(ADDRESS) Prosperity, Mo

Filed Mch 14 1914 R. E. Andrews, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 24, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 15, 1914, to March 24, 1914, that I last saw him alive on March 23, 1914, and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): Measles

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. W. Jeans M. D.

March 24, 1914 (Address) Prosperity, 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: Carterville Cem.

DATE OF BURIAL: Mar. 25, 1914

UNDERTAKER: Webb City Und Co.

ADDRESS: Webb City

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, peritonaeum,* 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," "C[illegible]se," "Coma," "Convulsions," "Deb[illegible]enile," etc.), "Dropsy," "P[illegible]" "Haemorrhage," "Ina[illegible]ge," "Shock," "Uraemia," [illegible]hen a definite disease can be as[illegible]tain [illegible] th[illegible] Always qualify all diseases resulting from [illegible]n or miscarriage, as "PUERPERAL *septichaemia,*" [illegible]RPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For vio[illegible] 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.)

HUGH STEPHENS, JEFFERSON CITY.

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 Jasper

Township or Village or City Prosperity (NO. ____ St.: ____ Ward)

Registration District No. 414 File No. 8

Primary Registration District No. 4246 Registered No. 8

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

FULL NAME Everett Adison Cowdry

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

DATE OF BIRTH ____ (Month) ____ (Day), 1__ (Year)

AGE ____ mos. ____ ds. If LESS than 1 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 ____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Filed 3/14, 1914 R. E. Andrews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/24 (Month) ____ (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw h____ alive on ____, 191__, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar 92

____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Measles

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. W. Joan M. D.

3/24, 1914 (Address) Prosperity 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 ____ DATE OF BURIAL ____, 191__

UNDERTAKER ____ ADDRESS ____

Original file, date ____, 19__ All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

...mation should be carefully supplied. ☐ AGE should be stated EXACTLY. PHYSICIANS should state ... 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]

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