

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

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

Registration District No. 703 File No. 14891
Primary Registration District No. 4482 Registered No. _____

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

FULL NAME William James McKasson

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE ma MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Sept. 13, 1844
(Month) (Day) (Year)
AGE 69 yrs. 7 mos. 8 ds. IF LESS than 1 day, 14 hrs. or ? min.?
OCCUPATION (a) Trade, profession, or particular kind of work carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH Apr 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1911, to Apr 21, 1914, that I last saw him alive on Apr 19, 1914, and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

92A
92B Apoplexy 64

BIRTHPLACE (City or town, State or foreign country) Ohio
PARENTS
NAME OF FATHER George McKasson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Ann Avis
BIRTHPLACE OF MOTHER (City or town, State or foreign country) New Jersey

(Duration) _____ yrs. _____ mos. 4 ds.
Contributory Valvular Heart
(Secondary) about
seasickness (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Keller M. D.
Apr 21, 1914 (Address) Glennwood 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 Exelata Mo DATE OF BURIAL Apr 22, 1914
UNDERTAKER Jac Ketting ADDRESS Glennwood Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah McKasson
(ADDRESS) Glennwood Mo
Filed Apr 21, 1914
J. H. Keller REGISTRAR

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) *Colton 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, 8 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 "Asthemia," "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.)

STATE OF MISSOURI. Exact statement of OCCUPATION is very important. No fee should be stated EXCEPT PHYSICIANS should state.

PLACE OF DEATH

County Schuyler

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

Township Glenwood

Registration District No. 803

File No. 14891

Village Glenwood

Primary Registration District No. 4482

Registered No. _____

City _____

(NO. _____) St.: _____ Ward _____

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

FULL NAME William James McKasson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH April 21, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, 1 _____, 19____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

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

The CAUSE OF DEATH* was as follows _____

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

(Duration) _____ yrs. _____ mos. _____ ds. Satisfactory Information Supplied.

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 19____ (Address) _____

PARENTS NAME OF FATHER George McKasson BIRTHPLACE OF FATHER _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER _____

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) Sarah McKasson

Former or usual residence _____

(ADDRESS) Glenwood Mo.

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 19____

Filed April 24, 1914 J. N. Kellish

UNDERTAKER _____ ADDRESS _____

REGISTRAR

Supplementary Information Supplied.

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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