

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

15752

PLACE OF DEATH
County DeWitt
Township Watkins
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 1162 File No. _____
Primary Registration District No. 5378-a Registered No. 19

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

FULL NAME Israel Black.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>December 25, 1826</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>3</u> mos. <u>26</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer.</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Penn.</u>		
PARENTS	NAME OF FATHER <u>William Black.</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>unknown</u>	
	MAIDEN NAME OF MOTHER <u>ca</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>ca</u>	

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from April 15, 1914, to April 21, 1914, that I last saw him alive on April 21, 1914, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Senility
162. 154

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) A. Sidney McParland M. D.
Apr. 22, 1914 (Address) Amst 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Billy Black.
(ADDRESS) Amst mo

PLACE OF BURIAL OR REMOVAL <u>Victor Cemetery</u>	DATE OF BURIAL <u>Apr. 22, 1914</u>
UNDERTAKER <u>Calvin Harms</u>	ADDRESS <u>Amst mo</u>

Filed May 10, 1914 REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death should be stated EXACTLY. Exact statement of OCCUPATION in 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, 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 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.

PLACE OF DEATH

County De Witt
Township Watkins

Registration District No. 1162 File No. _____

Village _____ Primary Registration District No. 5378a Registered No. 19

City _____ (NO. _____) Ward _____

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

FULL NAME

Israel Black

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE N. SINGLE, MARRIED, WIDOWED OR DIVORCED M.
(Write the word)

DATE OF BIRTH _____
(Month) _____ (Day) 1 (Year) _____

AGE _____
If LESS than 1 day, _____ hrs _____ or _____ min _____
_____ yrs _____ mos _____

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 May 10 1914 of Sidney McFarland
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1914
(Month) _____ (Day) _____ (Year) _____

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

Contributory _____
(SECONDARY) _____
(Duration) _____ yrs _____ mos _____ ds.

(Signed) _____
_____, 1914 (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 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 _____ ADDRESS _____

SUPPLEMENTARY Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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