

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

PLACE OF DEATH
County: Johnson
Township or Village or City: Rose Hill
Registration District No.: 437
Primary Registration District No.: 5594
File No.: 16485
Registered No.: 6

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

FULL NAME: Joseph Ivan Monday

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>March 21, 1901</u> (Month) (Day) (Year)		
AGE <u>13</u> yrs. <u>1</u> mos. <u>20</u> ds.		If LESS than 1 day, ... hrs. or ... min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Rose Hill, Missouri</u>		
PARENTS	NAME OF FATHER <u>George A Monday</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hendricks Ky</u>	
	MAIDEN NAME OF MOTHER <u>Leola Bailey</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Rose Hill, Missouri</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
5-10-1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 5 of an all 191 to 191, that I last saw him had on life 191, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:
Epilepsy which
existed from
birth, had an
invalid all life ds.
Contributory life
(SECONDARY) (Duration) 10 yrs. 0 mos. 0 ds.

(Signed) R. L. Bills M. D.
5-10-1914 (Address) Magnolia 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 10 yrs. 0 mos. 0 ds. In the State 10 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL
New Liberty Cem

DATE OF BURIAL
May 11, 1914

UNDERTAKER
L. B. Merritt

ADDRESS
Holden

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Loretta C. Monday
(ADDRESS) Holden Mo. St. Fe
Filed May 11, 1914
REGISTRAR J. S. [Signature]

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, 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Johnson
Township Rose Hill
Village _____
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 437 File No. 16485
Primary Registration District No. 0594 Registered No. 6

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

FULL NAME Gasper Ivan Monday

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W
SINGLE MARRIED WIDOWED OR DIVORCED
(If fill in word)

DATE OF DEATH May 10 1914
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____ information supplied, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

AGE _____ yrs. _____ 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 Geo. H. Monday
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) Recreta Monday
(ADDRESS) Golden Mo. R.F.D.

Filed _____, 19____ REGISTRAR _____

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

(Signed) _____ M. D.
_____, 19____ (Address) _____

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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 _____ 19____

UNDERTAKER _____ ADDRESS _____

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

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