

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

PLACE OF DEATH  
County Green

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Springfield Mo (NO. 960 Prospect Ave St.: 5 Ward)

Registration District No. 318  
Primary Registration District No. 2001

File No. 19143  
Registered No. 384

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

FULL NAME John B Smith

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

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

DATE OF BIRTH 7 - 17, 1865  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15, 1914, to June 22, 1914, that I last saw him alive on May 5, 1914

AGE 58 yrs. 11 mos. ds. IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

and that death occurred, on the date stated above, at 9:00 m.

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

The CAUSE OF DEATH was as follows:  
Chronic Hepatitis  
124B  
120B  
118C  
(Duration) 5 yrs. 11 mos. ds.

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

Contributory Indigestion  
(Secondary) 8 10 (Duration) 19 yrs. 2 mos. ds.

NAME OF FATHER Don't Know

BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

MAIDEN NAME OF MOTHER Don't Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

(Signed) J. H. Meadley M. D.  
June 22, 1914 (Address) Springfield

\*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) J. H. Meadley  
(ADDRESS) Springfield Mo

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 \_\_\_\_\_

Filed Jun 23, 1914 Edwin F. Law REGISTRAR

PLACE OF BURIAL OR REMOVAL Hazel Wood Cury DATE OF BURIAL 6-23-1914

UNDERTAKER Parker, Md ADDRESS 411 South St

# 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, 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*, *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 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.)

County Green

Township \_\_\_\_\_

Village \_\_\_\_\_

City Springfield (NO. \_\_\_\_\_)

Registration District No. 318

Primary Registration District No. 2001

File No. \_\_\_\_\_

Registered No. 384

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

FULL NAME

John B Smith

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

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 \_\_\_\_\_ 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 June 7 1944 Registrar Edna Gray

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 21 1944 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 1944, to \_\_\_\_\_ 1944, that I last saw him alive on \_\_\_\_\_ 1944, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Chronic Hepatitis  
Gastroenteritis  
Indigestion

Contributor (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) [Signature] (Address) Springfield

\*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 \_\_\_\_\_ 1944

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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