

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

PLACE OF DEATH

County Green
Township W Campbell
or
Village _____
or
City Springfield (NO. _____ St.: _____ Ward _____)

Registration District No. 318

File No. 19160

Primary Registration District No. 5439

Registered No. 381

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

FULL NAME Joseph Franklin Hines

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married
WIDOWED OR DIVORCED (If W, the word)

DATE OF BIRTH August 27, 1885
(Month) (Day) (Year)

AGE 58 yrs. 10 mos. ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Barber 131
(b) General nature of industry, business, or establishment in which employed (or employer) _____ 025

BIRTHPLACE (City or town, State or foreign country) Ohio 1063

PARENTS
NAME OF FATHER John Hines
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Abigail Vest
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J J Hines
(ADDRESS) Lexington Ill

Filed June 27, 1914 Worth County
Edw H Jones REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 20th, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 20, 1914, to June 20, 1914, that I last saw him alive on June 20, 1914, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Nephritis & Bronchitis
and acute conditions
(Duration) not known yrs. _____ mos. _____ ds.

Contributory not known the primary
(SECONDARY) conditional
as cause in only year death
(Signed) _____ M. D.
June 27, 1914 (Address) Springfield 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 Green Lawn DATE OF BURIAL June 20, 1914
UNDERTAKER W F Major ADDRESS Old Mo

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 septicæmia," "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 Greene

Township _____

Village _____

City Springfield

Registration District No. 318

Primary Registration District No. 5439

File No. _____

Registered No. 381

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

FULL NAME Joseph F. Harris

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 June 30, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, 191____
(Month) (Day) (Year)

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 _____ 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) _____

Typhoid - Bronchitis & Endocarditis
Chronic
(Duration) 17 yrs. 0 mos. 0 ds.

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

Contributors (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) J. M. Mason M. D. June 20, 1914 (Address) _____

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) _____

*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 _____ usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

Filed June 22, 1914 J. C. Dewitt REGISTRAR

UNDERTAKER _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Cause of DEATH should be carefully supplied. AGE should be given in years, months, and days. PHYSICIANS should state their names and positions. OCCUPATION is very important.

SUPPLEMENTARY Satisfactory Information Supplied.

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Revised United States Standard Certificate of Death

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

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