

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

19638

PLACE OF DEATH
County Jasper
Township Jackson
or Mountain Grove
Village Mountain Grove
or Mountain Grove
City Mountain Grove (NO. _____ St. _____ Ward _____)

Registration District No. 408 File No. _____
Primary Registration District No. 5562 Registered No. 104

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

FULL NAME Rueben Sheets

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE Widowed
MARRIED OR DIVORCED (If write the word)
DATE OF BIRTH May 20, 1853
(Month) (Day) (Year)
AGE 61 yrs. 1 mos. 5 ds. IF LESS than 1 day, ___ hrs. or ___ min. ?
OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS
NAME OF FATHER Wm D. Sheets
BIRTHPLACE OF FATHER (City or town, State or foreign country) N. Carolina
MAIDEN NAME OF MOTHER Emeline Pepper
BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. Carolina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. N. Johnson Supt
(ADDRESS) Coarthage, Mo

Filed June 25 1914 W E Seale
REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 25, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 5, 1912, to June 22, 1914, that I last saw him alive on June 22, 1914, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:
Bronchitis

10 1/2 B
76 B
(Duration) ___ yrs. 3 mos. ___ ds.

Contributory Morphine habit
(SECONDARY) (Duration) 2 yrs. ___ mos. ___ ds.

(Signed) W E Seale M. D.
June 25, 1914 (Address) Coarthage, 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 3 yrs. 2 mos. 18 ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted If not at place of death?
Former or usual residence Coarthage, Mo

PLACE OF BURIAL OR REMOVAL County Farm DATE OF BURIAL June 25, 1914

UNDERTAKER L N Johnson ADDRESS Coarthage, 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 *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.)

Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

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

County Jasper
Township Jackson
Village _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 408 File No. _____
Primary Registration District No. 5563 Registered No. 104

FULL NAME Ruben Sheets

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH 6/25, 1914
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____
Satisfactory Information Supplied, _____, 1914

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

that I last saw him _____ alive on _____, 1914
and that death occurred, on the date stated above, at 3a m.

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

CAUSE OF DEATH* was as follows:
Bronchitis
Chronic

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

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

NAME OF FATHER _____

Contributory (SECONDARY) Morphae Leth

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

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W E Stude M. D.
425 (Address) _____

MAIDEN NAME 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.

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

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 (Informant) _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

Filed 6/25 1914 W E Stude REGISTRAR

UNDERTAKER E. Johnson

Original file, date _____, 1914 All information called for must be written on this Supplementary Certificate.

Satisfactory Information Supplied

PARENTS

SUPPLEMENTARY

EARLY

Revised United States Standard Certificate of Death

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

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