

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 Jackson  
Township Smia-bar Registration District No. 395 File No. 22564  
Village Blue Springs or Primary Registration District No. 3551a Registered No. 138  
City Mo (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Amos Parr

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>July 26</u> , 191 <u>4</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Oct 1</u> , 18 <u>45</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>April 21</u> , 191 <u>4</u> , to <u>July 26</u> , 191 <u>4</u> , that I last saw him alive on <u>July 20</u> , 191 <u>4</u> , and that death occurred, on the date stated above, at <u>8:00 P.M.</u>	
AGE <u>68</u> yrs. <u>9</u> mos. <u>26</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Acute Pneumonia</u> <u>51B</u> <u>132B</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>			Contributory <u>Carcinoma</u> (SECONDARY) (Duration) <u>20</u> yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Joseph Parr</u>		(Signed) <u>J. H. Sawford</u> M. D. <u>July 27</u> , 191 <u>4</u> (Address) <u>Blue Springs Mo</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER <u>Hannah Johnson</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>		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) <u>Rosa Parr</u> (ADDRESS) <u>Blue Springs Mo</u>				
Filed <u>July 27</u> , 191 <u>4</u> , <u>J. H. Sawford</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Blue Springs Mo</u> DATE OF BURIAL <u>July 27</u> , 191 <u>4</u>	
			UNDERTAKER <u>J. W. Stanley</u> ADDRESS <u>Blue Springs Mo</u>	

# 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, 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.)

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

PLACE OF DEATH

Jackson  
Sinclair

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 Jackson  
Township Sinclair  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 395  
Primary Registration District No. 5551A

File No. \_\_\_\_\_  
Registered No. 138

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

FULL NAME Amos Parr

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, _____, 191____ (Month) (Day) (Year)		
AGE ____ yrs. ____ mos. ____ ds.		IF LESS than 1 day, ____ hrs ____ min. ____ sec.
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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 26 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h. \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

The CAUSE OF DEATH was as follows:  
Acute Myocardial  
Cancer of Bladder wall  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Cocci  
(SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Dr. J. B. Crawford M.D.  
July 27 1914 (Address) Blue Spgs Mo

SUPPLEMENTARY Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
Filed Sept 4 1914 REGISTRAR \_\_\_\_\_

\*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 \_\_\_\_\_, 191\_\_\_\_  
ADDRESS \_\_\_\_\_

UNDERTAKER \_\_\_\_\_

Original file, date 12 14 1914 All information called for must be written on this Supplementary Certificate.

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