

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 Miss
Township St Johns
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 527 File No. 23348
Primary Registration District No. 5703 Registered No. 44

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

FULL NAME John Wood

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>X</u>
DATE OF BIRTH <u>July 4, 1914</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>6</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ <u>X</u>		
BIRTHPLACE (City or town, State or foreign country) <u>East Prairie Mo</u>		
PARENTS	NAME OF FATHER <u>John Woods</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>	
	MAIDEN NAME OF MOTHER <u>Mabel Hyde</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>ky</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 10, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 10, 1914, to July 10, 1914, that I last saw him alive on July 10, 1914, and that death occurred, on the date stated above, at 90 m. The CAUSE OF DEATH* was as follows:

MI

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

Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. D. Davis M. D.
July 11, 1914 (Address) East Prairie 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Wood
(ADDRESS) East Prairie
Filed July 11, 1914 J. D. Davis REGISTRAR

PLACE OF BURIAL OR REMOVAL Ill Mo DATE OF BURIAL July 11, 1914
UNDERTAKER Lee Shelby ADDRESS East Prairie

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, 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*, *Sar-*

coma, 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.)

HUGH STEPHENS, JEFFERSON CITY.



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

PLACE OF DEATH

County

Township
or
Village
or
City

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

Registration District No.

Primary Registration District No.

File No.

Registered No.

(NO.

St.

Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH

July 10, 19*14*
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____,

AGE

____ yrs. ____ mos. *Satisfactory Information Supplied.*

If LESS than 1 day, ____ hrs. or ____ min. >

and that death occurred, on the date stated above, at ____ m.

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)

Don't know

BIRTHPLACE

(City or town, State or foreign country)

Contributory (Duration) ____ yrs. ____ mos. ____ ds.

NAME OF FATHER

(Signed) *J. J. Deane* M. D.
July 11 1914 (Address) *East Prairie Mo*

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

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At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Filed

July 11 1914 *J. J. Deane* REGISTRAR

Satisfactory Information Supplied

Should be stated EXACTLY. PHYSICIANS should properly classified. Exact statement of OCCUPATION is very important, so that it may be properly classified.

SUPPLEMENTARY INFORMATION Supplied.

Revised United States Standard Certificate of Death

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

23348

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