

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

PLACE OF DEATH

County Green

Township _____

Registration District No. 318

File No. 25893

or Village _____

Primary Registration District No. 2001

Registered No. 576

or City Springfield (NO. 618 5 Jefferson St. First Ward)

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

FULL NAME John Maloney Chrisman

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 24 1914
(Month) (Day) (Year)

DATE OF BIRTH October 23 1841
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 3, 1914, to Aug 24, 1914, that I last saw him live on Aug 24, 1914, and that death occurred, on the date stated above, at 11:30 a.m.

AGE 72 yrs. 10 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Uremia
131
137 B

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

BIRTHPLACE (City or town, State or foreign country) Lee County Virginia

NAME OF FATHER Gabriel Scott Chrisman

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

MAIDEN NAME OF MOTHER Margaret Maloney

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

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Bright's Disease (SECONDARY)

(Signed) J. H. ... M. D. (Duration) ___ yrs. ___ mos. ___ ds.

(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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Chrisman

(ADDRESS) 969 Kings Highway

PLACE OF BURIAL OR REMOVAL Hazelwood cem

DATE OF BURIAL _____ 1914

Filed Aug 24 1914 Clara H. James REGISTRAR

UNDERTAKER Peas on and co. ADDRESS 410 South W

All 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, 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.)

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETELY PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH
Home
County _____
Township _____
or
Village _____
or
City _____

Registration District No. *318* File No. _____
Primary Registration District No. *2001* Registered No. *516*
Ward _____

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

FULL NAME *John Maloney Christmas*

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

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

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

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 *Aug 24* 191*4* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Aug 24*, 191*4*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____
Satisfactory Information Supplied., 191____,
that I last saw h. _____ alive on _____, 191____,
and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH was as follows:
Asphyxia
Chorea Repetitiva
Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) *Bright's Dis.*
Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *W. G. Williams* M. D.
Aug 24 (Address) _____

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 _____ 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____

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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