

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.

PLACE OF DEATH

County Henry
Township _____
or
Village _____
or
City Windsor (No. _____)

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

Registration District No. 14

File No. 25942

Primary Registration District No. 4211

Registered No. 30

St.: _____ Ward: _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME J. H. Bowen

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Aug 18 84
(Month) (Day) (Year)

AGE 68 yrs. 12 mos. 12 ds. IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) None

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

PARENTS
NAME OF FATHER William Bowen

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

MAIDEN NAME OF MOTHER Hally Lynn

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Bowen

(ADDRESS) Windsor

Filed Aug 30 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 30, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 16, 1914, to Aug 30, 1914,
that I last saw him alive on Aug 30, 1914,
and that death occurred, on the date stated above, at 7:30 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Heart trouble with nephritis.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY) (Duration) _____ yrs. 6 mos. _____ ds.

(Signed) H. Walton M. D.
Aug 30 1914 (Address) Windsor 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 Catholic Hye DATE OF BURIAL Sept 2 1914

UNDERTAKER Chas A Carter ADDRESS Windsor

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.)

N. B.—E. 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.

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	<u>Henry</u>	Registration District No.	<u>14</u>	File No.	
Township		Primary Registration District No.	<u>4211</u>	Registered No.	<u>30</u>
or		St.		Ward	
Village	<u>Hudson</u>				
or					
City	<u>Hudson</u>				
FULL NAME <u>John R. Bovey</u>					
(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	<u>M</u>	COLOR OR RACE	<u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)	<u>W</u>
DATE OF BIRTH			DATE OF DEATH		
(Month) (Day) (Year)			(Month) (Day) (Year)		
AGE			I HEREBY CERTIFY, that I am a		
yrs. ds.			Satisfactory Information Supplied		
OCCUPATION			that I last saw h alive on		
(a) Trade, profession, or particular kind of work			and that death occurred, on the date stated above, at		
(b) General nature of industry, business, or establishment in which employed (or employer)			m.		
BIRTHPLACE			CAUSE OF DEATH* was as follows:		
(City or town, State or foreign country)			<u>Chronic Heart trouble with Rheumatism</u>		
NAME OF FATHER			<u>Plute. 1/1/1914</u>		
BIRTHPLACE OF FATHER			(Duration) yrs. mos. ds.		
(City or town, State or foreign country)			Contributory		
MAIDEN NAME OF MOTHER			(SECONDARY)		
BIRTHPLACE OF MOTHER			(Duration) yrs. mos. ds.		
(City or town, State or foreign country)			(Signed)		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			<u>May 30, 1914</u> (Address) <u>Shulton</u>		
(Informant)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
(ADDRESS)			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
Filed <u>May 30, 1914</u>			At place of death, yrs. mos. ds. In the State yrs. mos. ds.		
REGISTRAR			Where was disease contracted if not at place of death?		
			Former or usual residence.		
			PLACE OF BURIAL OR REMOVAL		
			DATE OF BURIAL		
			UNDERTAKER		
			ADDRESS		

Revised United States Standard Certificate of Death

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

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