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

PLACE OF DEATH

County: Stoddard

Township: Castor Tp

or Village:

or City: (NO. , St.: Ward)

Registration District No. 837 File No. 31173

Primary Registration District No. 6099 Registered No. 63

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

FULL NAME John Harmon Kenneth Howard

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: October (Month) 6 (Day), 1913 (Year)

AGE: yrs. 10 mos. 28 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

BIRTHPLACE (City or town, State or foreign country): Castor Township

PARENTS
NAME OF FATHER: Harmon J. Howard
BIRTHPLACE OF FATHER (City or town, State or foreign country): Stoddard Co Mo
MAIDEN NAME OF MOTHER: Florence A. Capps
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Stoddard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harmon J Howard

(ADDRESS) Bloomfield Mo

Filed Sept. 4, 1914. John A. Wilson M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September (Month) 4 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from August 15, 1914, to August 31, 1914, that I last saw him alive on Aug 25, 1914, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Child was never strong. Had measles in April 1914 which left him with cough developed pneumonia Aug 28th 1914

(Duration) yrs. 1 mos. ds.

Contributory (SECONDARY) former attack of measles (Duration) yrs. 4 mos. — ds.

(Signed) Thos B. Turnbaugh M. D.

Sept 4 1914 (Address) Bloomfield 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: Walker Cemetery

DATE OF BURIAL: Sept. 5, 1914

UNDERTAKER: Bennett Bros.

ADDRESS: Bloomfield, Mo.

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 *septichaemia*," "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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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

PLACE OF DEATH

County: Stoddard

Township: Castor

or Village: ____

or City: ____ (NO. ____ St.: ____ Ward)

Registration District No. 837 File No. ____

Primary Registration District No. 6099 Registered No. 63

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

FULL NAME John H. B. Howard

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W.

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): S.

DATE OF BIRTH: ____ (Month) ____ (Day) 1____ (Year)

Satisfactory Information Supplied.

AGE: ____ yrs. ____ mos. ____ days. If LESS than 1 day, ____ hrs. or ____ min.

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

Satisfactory Information Supplied.

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): ____

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Satisfactory Information Supplied.

Filed Oct. 27, 19__ John W. Lisonbee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 4 (Month) 4 (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw h____ alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia 9 1

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

Contributory (Secondary) ____

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

(Signed) Tom Turnbaugh M.D.

9/14/ 191 4 (Address) Bloomfield 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 ____

Satisfactory Information Supplied.

PLACE OF BURIAL OR REMOVAL ____ DATE OF BURIAL ____, 191__

UNDERTAKER ____ ADDRESS ____

SUPPLEMENTARY

SEF 121

Original file, date ____ 19__ All information called for must be written on this Supplementary Certificate.

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]

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