

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

PLACE OF DEATH  
County Gallatin  
Township Clay  
or  
Village  
or  
City

Registration District No. 728 File No. 333163 12  
Primary Registration District No. 5961 Registered No. 62  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Woodson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED Married  
(If wife the word)  
DATE OF BIRTH Not Known, 1913  
(Month) (Day) (Year)  
AGE 71 yrs. — mos. — ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE  
(City or town, State or foreign country) Marion Co. Mo.

PARENTS  
NAME OF FATHER Not Known  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not Known  
MAIDEN NAME OF MOTHER Not Known  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norace Foster  
(ADDRESS) Wetters Mill

Filed Oct 21, 1914, J. H. Gould  
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 19, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 3, 1914, to Oct. 19, 1914, that I last saw him alive on Oct 13, 1914, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Heber Jorsten  
153 B  
123 D  
84 (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

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

(Signed) P. J. Reichmann M. D.  
Oct. 20, 1914 (Address) Rensselaer 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 Big Creek County, Mo. DATE OF BURIAL Oct 22, 1914  
UNDERTAKER W. H. Wilson ADDRESS Mound City, Mo.

# 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, 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 moving 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.)

Exact statement of cause of death is very important.

| PLACE OF DEATH                                                                                                                                                            |                                                                        |                                                                 | REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.                                                                                                        |  | BUREAU OF VITAL STATISTICS<br>CITY OF CHICAGO<br>CITY OF DEATH                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| County <u>Kauai</u>                                                                                                                                                       |                                                                        |                                                                 | Registration District No. <u>728</u>                                                                                                                                                                      |  | File No. _____                                                                               |  |
| Township _____                                                                                                                                                            |                                                                        |                                                                 | Primary Registration District No. <u>5961</u>                                                                                                                                                             |  | Registered No. <u>62</u>                                                                     |  |
| Village _____                                                                                                                                                             |                                                                        |                                                                 | (NO. _____ St. _____ Ward _____)                                                                                                                                                                          |  | [If death occurred in a hospital or institution, give its NAME instead of street and number] |  |
| City _____                                                                                                                                                                |                                                                        |                                                                 | FULL NAME <u>John Woodson</u>                                                                                                                                                                             |  |                                                                                              |  |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                      |                                                                        |                                                                 |                                                                                                                                                                                                           |  | MEDICAL CERTIFICATE OF DEATH                                                                 |  |
| SEX <u>M</u>                                                                                                                                                              | COLOR OR RACE <u>B</u>                                                 | SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u><br>(Write the word) | DATE OF DEATH <u>Oct 19</u> , 191 <u>4</u><br>(Month) (Day) (Year)                                                                                                                                        |  |                                                                                              |  |
| DATE OF BIRTH _____<br>(Month) (Day) (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 <u>10 P.</u> m. |  |                                                                                              |  |
| AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.                                                                                          |                                                                        |                                                                 | The CAUSE OF DEATH was as follows:<br><u>Intestinal Autolmia</u><br><u>Contributory Old age &amp; unsanitary surroundings. poor food.</u><br>(Duration) _____ yrs. _____ mos. _____ ds.                   |  |                                                                                              |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |                                                                        |                                                                 | (Signed) <u>P. J. Reichmann</u> M. D.<br><u>Oct 22</u> , 191 <u>4</u> (Address) <u>Russell Ave.</u>                                                                                                       |  |                                                                                              |  |
| BIRTHPLACE<br>(City or town, State or foreign country) _____                                                                                                              |                                                                        |                                                                 | *State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.                                                             |  |                                                                                              |  |
| PARENTS                                                                                                                                                                   | NAME OF FATHER _____                                                   |                                                                 | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.                      |  |                                                                                              |  |
|                                                                                                                                                                           | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) _____ |                                                                 | Where was disease contracted if not at place of death? _____                                                                                                                                              |  |                                                                                              |  |
|                                                                                                                                                                           | MAIDEN NAME OF MOTHER _____                                            |                                                                 | Former or usual residence _____                                                                                                                                                                           |  |                                                                                              |  |
|                                                                                                                                                                           | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) _____ |                                                                 | PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____                                                                                                                                            |  |                                                                                              |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) _____<br>(ADDRESS) _____                                                                                     |                                                                        |                                                                 | UNDERTAKER _____ ADDRESS _____                                                                                                                                                                            |  |                                                                                              |  |
| Filed <u>Oct 21</u> , 191 <u>4</u> <u>J. H. Gould</u> REGISTRAR                                                                                                           |                                                                        |                                                                 |                                                                                                                                                                                                           |  |                                                                                              |  |

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