

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

37940

PLACE OF DEATH
County Boone
Township Centerville Registration District No. 92 File No.
or
Village _____ Primary Registration District No. 4041 Registered No. 41
or
City Centerville (NO _____) St. _____ Ward _____

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

FULL NAME John Ansel Eveman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If write the word)

DATE OF BIRTH Nov 20, 1835
(Month) (Day) (Year)

AGE 79 yrs. 2 mos. 27 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Clark County Ky

PARENTS
NAME OF FATHER Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. S. Kalmbach
(ADDRESS) Centerville, Mo

Filed Dec. 21 1914 J. H. Dickerson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 19, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 11, 1914, to Dec 17, 1914, that I last saw him alive on Dec 17, 1914, and that death occurred, on the date stated above, at 8:20 am.

The CAUSE OF DEATH* was as follows:
Pneumonia
187A
135B

Contributory Septic Chronic
(SECONDARY) (Duration) 18 yrs. ____ mos. ____ ds.
(Signed) W. A. McLaughlin M. D.
Dec-19, 1914 (Address) Centerville 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 Grace Church DATE OF BURIAL Dec 21, 1914
UNDERTAKER W. A. McLaughlin ADDRESS Centerville

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*, *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 septicæmia," "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.)

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County Boone

Township _____

Registration District No. 72

File No. 37937-B

or Village _____

Primary Registration District No. 4041

Registered No. 41

or City Centerville (NO. _____)

St. _____ Ward _____

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

FULL NAME John A. Everman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____ 1914
(Month) (Day) (Year)

DATE OF BIRTH _____ 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ 1911
Satisfactory information supplied _____ 1911

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

that I last saw him alive on _____ 1911
and that death occurred, on the date stated above, at _____ a.m.

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

THE CAUSE OF DEATH was as follows:
Pneumonia
Broncho-Pneumonia

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

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

NAME OF FATHER _____

Contributory (SECONDARY) Cystitis, Chills

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

(Signed) W. A. McAllister M. D.
1914 (Address) Centerville

MAIDEN NAME OF MOTHER _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

Filed 2/17/21 1914 W. A. McAllister REGISTRAR

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION Supplied.

Revised United States Standard Certificate of Death

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

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