

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39179

1 PLACE OF DEATH
County Jasper
Township Joplin Tp
or Porto Rico, Mo.
Village St. Albans
or St. Albans
City (NO. St.: Ward)

Registration District No. 414 File No. 36
Primary Registration District No. 5561 C Registered No. 776

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

2 FULL NAME John L. Curry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH Nov. 1894
(Month) (Day) (Year)

16 DATE OF DEATH Dec. 13, 1914
(Month) (Day) (Year)

7 AGE about 40 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

17 I HEREBY CERTIFY, that I attended deceased from 191 to Dec. 13, 1914, that I last saw him on Dec. 14, 1914, and that death occurred, on the date stated above, at 6 P.M.

8 OCCUPATION (a) Trade, profession, or particular kind of work Miner
(b) General nature of industry business or establishment in which employed (or employer) zinc & lead

The CAUSE OF DEATH* was as follows:
Killed by gun that
wound
173 Homicidal
(Duration) yrs. mos. ds.

9 BIRTHPLACE (City or town, State or foreign country) Not known

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) D. Snyder M. D.
Dec. 14, 1914 (Address) Corner

PARENTS
10 NAME OF FATHER " "
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) " "
12 MAIDEN NAME OF MOTHER " "
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) " "

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Coily Ind. Co.
(Address) W. H. Coily Mo.

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.

15 Filed Dec. 28, 1914 L. B. Cheenoweth Registrar

19 PLACE OF BURIAL OR REMOVAL W. H. Coily, Mo. DATE OF BURIAL Dec. 28, 1914
20 UNDERTAKER W. H. Coily, Ind. Co. ADDRESS W. H. Coily, Mo.

Mrs. Mary Saxton Registrar

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, 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*, (c) *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 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.)

PLACE OF DEATH

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

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

County Jasper Registration District No. 414 File No. 39179
 Township Port Rico or Village _____ Primary Registration District No. 5561e Registered No. _____
 or City _____ (NO. _____) St.; _____ Ward _____

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

FULL NAME John L. Curry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)	DATE OF DEATH <u>Dec. 13, 1914</u> (Month) (Day) (Year)
DATE OF BIRTH _____, 191____, to _____, 191____ (Month) (Day) (Year)			HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on <u>Dec. 14, 1914</u> , and that death occurred, on the date stated above, at _____ m.
AGE ____ yrs. ____ mos. ____ ds.			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) _____			The CAUSE OF DEATH* was as follows: _____ _____ _____
BIRTHPLACE (City or town, State or foreign country) _____			(Duration) ____ yrs. ____ mos. ____ ds.
PARENTS	NAME OF FATHER _____		Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		(Signed) _____ M. D.
	MAIDEN NAME OF MOTHER _____		_____, 191____ (Address) _____
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
(Informant) _____ _____ (ADDRESS) _____			Where was disease contracted if not at place of death? _____ Former or usual residence _____
Filed <u>Aug. 26 1915</u> <u>Dec. 28 1914</u> <u>Mrs. Mary Postour</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL <u>Dec 28 1914</u> UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

Original file, date FEB 19 1915 All information called for must be written on this Supplementary Certificate.

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.

Revised United States Standard Certificate of Death

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

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