

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

41206

PLACE OF DEATH
County Paney
Township Branson
or
Village
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 859 File No. _____
Primary Registration District No. 6128 Registered No. 18

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

FULL NAME James David Hillhouse

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>April 22</u> , 18 <u>43</u> (Month) (Day) (Year)		
AGE <u>71</u> yrs. <u>8</u> mos. <u>6</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> <u>131</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>97A</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Ill. Marion</u>		
PARENTS	NAME OF FATHER <u>James Hillhouse</u>	
	BIRTHPLACE OF FATHER <u>Ill.</u>	
	MAIDEN NAME OF MOTHER <u>Anne Davis</u>	
	BIRTHPLACE OF MOTHER <u>U. S.</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 28, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March, 1911, to Dec, 1914, that I last saw him alive on Dec 22, 1914, and that death occurred, on the date stated above, at 12.20 o'clock.

The CAUSE OF DEATH* was as follows:
Cardiac Hypertrophy & Coronary Insufficiency

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Mephitus A
(Secondary) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Ray B. Mitchell M. D.
Dec 28, 1914 (Address) Branson Mo

* 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
(Informant) Elmer Hillhouse
(ADDRESS) Branson Mo

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 _____

Filed Dec 28, 1914 G. W. Gloyd, M.D.
REGISTRAR

PLACE OF BURIAL OR REMOVAL Branson Mo DATE OF BURIAL Dec 28, 1914
UNDERTAKER Osker Welchel ADDRESS Branson 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*, *Sar-*

coma, 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.)



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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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PLACE OF DEATH Jamez
 County Branson
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

REGISTRATION DISTRICT NO. 859 FILE NO. _____
 PRIMARY REGISTRATION DISTRICT NO. 6138 REGISTERED NO. 18

FULL NAME James David Hillhouse

[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 <u>M</u> (Write the word)	DATE OF DEATH <u>DEC 28</u> , 191 <u>4</u> (Month) (Day) (Year)
DATE OF BIRTH _____, _____, 191____ (Month) (Day) (Year)		HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at <u>12:20</u> m.	
AGE _____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. _____ min. or _____ min.	CAUSE OF DEATH* was as follows: <u>Andrie Hypertrophy & Volvulus Intestines</u> <u>Chronic Nephritis</u> (Duration) <u>5</u> yrs. _____ mos. _____ ds.	
OCCUPATION: (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		Contributory <u>Nephritis</u> (Duration) <u>7</u> yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____		(Signed) <u>Guy B. Mitchell</u> M.D. <u>1728</u> 191 <u>4</u> (Address) <u>Branson Mo.</u>	
PARENTS	NAME OF FATHER _____	*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 FATHER (City or town, State or foreign country) _____	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER _____	At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	Where was disease contracted if not at place of death? _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____		Former or usual residence _____	
FILED <u>17/28</u> 191 <u>4</u> <u>G. W. Lloyd M.D.</u> REGISTRAR		PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 191____
		UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY INFORMATION Supplied Separately

Revised United States Standard Certificate of Death

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

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