

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

PLACE OF DEATH
County Texas
Township Waco Registration District No. 865 File No. 41214
Village _____ Primary Registration District No. 6143 Registered No. _____
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Joel Robert Mead

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH January 9th 1911
(Month) (Day) (Year)
AGE 3 yrs. 10 mos. 2 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

DATE OF DEATH November 11, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 27, 1914, to Nov 11, 1914 that I last saw him alive on Nov 11, 1914 and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

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

1 Typhoid Fever

BIRTHPLACE (City or town, State or foreign country) Texas County Mo

(Duration) _____ yrs. _____ mos. 16 ds.

NAME OF FATHER Joel blinton Mead

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

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

(Signed) R. Husband M. D.

MAIDEN NAME OF MOTHER Grace G. Sigman

(Address) Carroll Mo

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) R. Husband
(ADDRESS) Carroll 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 _____

Filed Dec 1914 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191_____

UNDERTAKER W. C. ... ADDRESS Carroll Mo.

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]

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*, *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.)

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

PLACE OF DEATH

County Jackson

Township Cass

Village _____

City _____ (NO. _____)

Registration District No. 865

Primary Registration District No. 6143

File No. _____

Registered No. 18

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

FULL NAME

Joel Robert Mead

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1914
(Month) Nov (Day) 15 (Year)

DATE OF BIRTH Satisfactory 4, 1911
(Month) _____ (Day) _____ (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1914, to Nov 15, 1914, that I last saw him alive on Nov 15, 1914, and that death occurred, on the date stated above, at 4 P m.

AGE 3 yrs. 10 mos. 2 ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:

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

Typhoid Fever

BIRTHPLACE (City or town, State or foreign country) Texas, Mo

NAME OF FATHER Joel Robert Mead

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

MAIDEN NAME OF MOTHER Seed Sigmon

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

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

(Signed) H. P. Hubbard M. D.

Nov 15, 1914 (Address) Kebon

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. P. Hubbard

(ADDRESS) Kebon

PLACE OF BURIAL OR REMOVAL Wood Cemetery DATE OF BURIAL Nov 16, 1914

Filed Jan 9, 1914 H. G. W. Keim REGISTRAR

UNDERTAKER: W. S. Cleburne ADDRESS Kebon

A copy of this certificate is to be retained in the files of the Bureau of Vital Statistics, Missouri State Board of Health, St. Louis, Mo. Physicians should state exact statement of occupation is very important.

Revised United States Standard Certificate of Death

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

41214

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