

PLACE OF DEATH

County: Macon
 Township: Hudson
 or
 Village:
 or
 City: Macon (NO. _____) St.: _____ Ward: _____

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

Registration District No. 533
 Primary Registration District No. 3027

File No. _____
 Registered No. 15-05360

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

FULL NAME Joe Lewis

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>July 14</u> , 18 <u>54</u> (Month) (Day) (Year)		
AGE <u>60</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

BIRTHPLACE

(City or town,
State or foreign country)

Shelby Co.

PARENTS

NAME OF FATHER

Do not know

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

Do not know

MAIDEN NAME OF MOTHER

Do not know

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

Do not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Markus Lewis(ADDRESS) Hennibal MoFiled 2-10 1915

W. Miller
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2/2, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1914, to Feb 1, 1915, that I last saw him alive on Feb 1, 1915,

and that death occurred, on the date stated above, at 49 m.

The CAUSE OF DEATH* was as follows:

Uremia
131
132B

(Duration) 2 yrs. _____ mos. 30 ds.Contributory Nephritis

(SECONDARY)

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

(Signed) A. M. Kenner M. D.

Feb 2, 1915 (Address) Macon 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

New Canaan

DATE OF BURIAL

2/3, 1915

UNDERTAKER

Edw. Skinner

ADDRESS

Macon Mo.

(Copy)

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 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 CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Macou

Township _____

Registration District No. 533

File No. _____

or Village _____

Primary Registration District No. 3027

Registered No. 159

or City Macou

St. _____ Ward _____

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

FULL NAME

Joe Lewis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1915
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw him alive on _____, 1915, and that death occurred, on the date stated above, at 4:00 m.

AGE _____ yrs. _____ mos. _____ 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 _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

Uremia

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

(Duration) _____ yrs. _____ mos. 30 ds.

NAME OF FATHER _____

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

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

(Signed) W. D. Miller M. D.

MAIDEN NAME OF MOTHER _____

7/2, 1915 (Address) Macou Mo

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) _____

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

(ADDRESS) _____

Former or usual residence _____

Filed 2/10 1915 W. D. Miller

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915

UNDERTAKER _____ ADDRESS _____

REGISTRAR

Revised United States Standard Certificate of Death

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

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