

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

PLACE OF DEATH

County

Buchanan

Township

or

Village

or

City

St Joseph

(NO.

Registration District No.

85

File No.

7517

Primary Registration District No.

1007

Registered No.

256

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

FULL NAME *Elbridge John Rewell*

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

DATE OF DEATH

March

9th, 191*5*

(Month)

(Day)

(Year)

DATE OF BIRTH

Sept. 7th, 1842

(Month)

(Day)

(Year)

AGE

72 yrs. *6* mos. *2* ds.

If LESS than
1 day, ____ hrs.
or ____ min.?

I HEREBY CERTIFY, that I attended deceased from *March 3*, 191*5*, to *March 9*, 191*5*, that I last saw him alive on *Mar 9*, 191*5*, and that death occurred, on the date stated above, at *925a*.

The CAUSE OF DEATH* was as follows:

*Septic Infection of nose
a Burn over the throat*

OCCUPATION

(a) Trade, profession, or particular kind of work

Retired 181

(b) General nature of industry, business, or establishment in which employed (or employer)

Bookkeeper 36

BIRTHPLACE

(City or town, State or foreign country)

Conn. 718

(Duration) ____ yrs. ____ mos. *7* ds.

Contributory *Anemia*

(SECONDARY)

(Duration) *1* yrs. ____ mos. ____ ds.

NAME OF FATHER

John Rewell

BIRTHPLACE OF FATHER

(City or town, State or foreign country) *Germany*

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) *Conn.*

(Signed) *O. A. Meade* M. D.

Mar 9, 191*5* (Address) *St Joseph rd*

*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)

Mrs. L. J. Holland

(ADDRESS)

1314 Penn.

PLACE OF BURIAL OR REMOVAL

Mt. Mora Cemetery

DATE OF BURIAL

March 10, 1915

UNDERTAKER

V. Meierhoffer

ADDRESS

824 Felix St.

Filed

Mar 9, 191*5* *W. E. Harrington*

REGISTRAR

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, 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.)

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

PLACE OF DEATH
County Buchanan

Township _____
or
Village St. Joseph
City _____

Registration District No. 85 File No. _____

Primary Registration District No. 1001 Registered No. 256

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

FULL NAME

Elbridge John Rewell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Widowed

DATE OF DEATH 3/9, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

AGE 4 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) _____

Septic Infection of wound from a burn over the thorax (accidental) night shirt caught fire from lighting pipe in bed.
(Duration) _____ yrs. _____ mos. _____ ds.

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

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

NAME OF FATHER _____

(Signed) E.A. Mendenhall M.D. 3-9 1915 (Address) St. Joe, Mo.

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

MAIDEN NAME OF MOTHER _____

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)

(Informant) _____

At place of death Satisfactory mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) _____

Where was disease contracted If not at place of death _____

Former or usual residence _____

Filed May 24 1915 W.C. Harrington REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

UNDERTAKER _____ ADDRESS _____

Y. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. "AGE" and "CAUSE OF DEATH" in plain terms, so that it may be properly classified.

SUPPLEMENTARY Information Supplied.

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