

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

PLACE OF DEATH

County Jasper
Township Sheridan
or
Village ✓
or
City ✓ (NO. _____) St.: _____ Ward _____

Registration District No. 1045 File No. 8990
Primary Registration District No. 5568 Registered No. 1

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

FULL NAME John Edwin Carter

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Sept. - 4 - 1854
(Month) (Day) (Year)

AGE 60 yrs. 5 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Jasper, Co. Mo.

PARENTS

NAME OF FATHER James Carter

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

MAIDEN NAME OF MOTHER Frances Boster

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray C. Carter

(ADDRESS) Jasper, Mo.

Filed Mar 3 1915 H. S. Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 28 - 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 28 - 7 am - 1915, to Feb. 28 - 11 PM - 1915, that I last saw him alive on Feb. 28 - 1915, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
131
82
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ✓
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. H. Knott M. D.
Mar. 1 - 1915 (Address) Jasper, Mo.

*State the Disease Causing Death, or, in death 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 Jasper County, Mo.

PLACE OF BURIAL OR REMOVAL Mitchell Cemetery DATE OF BURIAL Mich 2 1915

UNDERTAKER Wuell and Co Carthage Mo. ADDRESS

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, peritonaeum*, 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 septichaemia," "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.)

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

B.—Every item of information should be carefully applied. 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.

PLACE OF DEATH

County

Township

or

Village

or

City

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

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

FULL NAME

John Edwin Carter

(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 M COLOR OF RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF DEATH Feb. 28, 1915
(Month) (Day) (Year)

DATE OF BIRTH Satisfactory Information Supplied
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied 1915, to Satisfactory Information Supplied, 1915, that I last saw him alive on Satisfactory Information Supplied, 1915, and that death occurred, on the date stated above, at Satisfactory Information Supplied m.

AGE Satisfactory Information Supplied 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)

Cerebral Haemorrhage
Chronic Parenchymatous Nephritis
(Duration) yrs. mos. ds.

BIRTHPLACE (City or town, State or foreign country)

Contributory (SECONDARY) 04
(Duration) yrs. mos. ds.

NAME OF FATHER

(Signed) W. Knatt M. D.
3-1-15 (Address) Jasper Mo.

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

MAIDEN NAME OF MOTHER

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 May 3 1915 Ed Johnston REGISTRAR

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

UNDERTAKER ADDRESS

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

Revised United States Standard Certificate of Death

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

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8990

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