

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

1 PLACE OF DEATH

County Osage Registration District No. 157 File No. 11894
Township Big Creek or Village Pleasant Hill Primary Registration District No. 5222 Registered No. _____
City Pleasant Hill (NO. _____) St. _____ Ward _____

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

2 FULL NAME Abram Parris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Oct 26 1927
(Month) (Day) (Year)

7 AGE 88 yrs. 5 mos 22 ds. It LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired 194
(b) General nature of industry, business, or establishment in which employed (or employer) 106 B

9 BIRTHPLACE (City or town, State or foreign country) Osage 36

PARENTS
10 NAME OF FATHER Wm Parris
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Parris
(Address) Pleasant Hill Mo

15 Filed Apr 18 1915 R.P. Page Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 16 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 5 1915 to Apr 15 1915, that I last saw him alive on Apr 15 1915, and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:

Streptococcal infection of right hand

(Duration) 20 yrs. 20 mos. 20 ds.
CONTRIBUTORY Chronic Bronchitis
(Secondary) (Duration) 5 yrs. 5 mos. 5 ds.
(Signed) H. Gerard M. D.
Apr 17 1915 (Address) P Hill Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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 _____

19 PLACE OF BURIAL OR REMOVAL Leitch Farm DATE OF BURIAL 4-20 1915

20 UNDERTAKER Barker & Son ADDRESS Pleasant Hill 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, 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

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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.)

If information is called for, AGE should be stated. EXACTLY. PHYSICIAN should state hospital or institution, give its NAME instead of street and number. If statement of OCCUPATION is not pertinent, so state. If information is not pertinent, so state.

PLACE OF DEATH

County Cass
 Township Big Creek
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

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

Registration District No. 157 File No. _____
 Primary Registration District No. 5722 Registered No. _____

FULL NAME Abraham Parris

[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 OR RACE W SINGLE W MARRIED W WIDOWED W OR DIVORCED W
(Write the word)

DATE OF DEATH Apr. 16, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

I 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 _____ m.

AGE _____ yrs. _____ mos. _____ ds.
 If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Streptococcal infection of heart from barbed wire cut or from jaw
(Duration) _____ 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 Chronic Bronchitis
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

(Signed) H. J. Ford M. D.
4/17, 1915 (Address) Pleasant Hill 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

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

UNDERTAKER _____ ADDRESS _____

Filed _____ 191____ REGISTRAR _____

APR - 1915

Revised United States Standard Certificate of Death

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

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