

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

PLACE OF DEATH

County Coppe
Township Hobbs
or
Village
or
City Brunswick (NO. _____ St.: _____ Ward)

Registration District No. 219 File No. 12039
Primary Registration District No. 4132 Registered No. 7

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

FULL NAME James F. Cracet

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE black SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH May 12, 1850
(Month) (Day) (Year)
AGE 64 yrs. 8 mos. 17 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) Mo.

PARENTS
NAME OF FATHER Grace Cracet
BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.
MAIDEN NAME OF MOTHER Mrs. C. Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phelix Cracet
(ADDRESS) Brunswick, Mo.

Filed Apr. 12th 1915 W. E. Elliott
REGISTRAR

DATE OF DEATH July 29, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 21, 1915, to July 29, 1915, that I last saw him alive on July 29, 1914, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH was as follows:
Acute Gastritis
131
118 C
(Duration) _____ yrs. _____ mos. 10 ds.

Contributory Nephritis
(SECONDARY) (Duration) _____ yrs. 9 mos. _____ ds.
(Signed) W. E. Elliott M. D.
July 30, 1915 (Address) Brunswick

*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 Brunswick, Mo. DATE OF BURIAL Jan 21, 1915
UNDERTAKER J. M. Wilson ADDRESS Brunswick, 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*, *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 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*, *telanus*) 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.)

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.

PLACE OF DEATH
 County Cooper
 Township _____ Registration District No. 219 File No. 7
 or _____
 Village _____ Primary Registration District No. 4132 Registered No. _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME James F. Crockett

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 Jan 29, 1915
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date stated above, at 1:30 m.

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

The CAUSE OF DEATH* was as follows:
Acute Gastritis

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

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

(Duration) _____ yrs. _____ mos. 10 ds.
 Contributory Chronic Nephritis
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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) P. E. Williams M.D.
Jan 30, 1915 (Address) Burnett

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

Where was disease contracted If not at place of death? _____
 Former or usual residence _____

(ADDRESS) _____

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

Filed Apr 10 1915 W. A. Elkins REGISTRAR

UNDERTAKER _____ ADDRESS _____

Original file, date Apr 10 1915 Information called for must be written on this Supplementary Certificate.

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.

Satisfactory Information Supplied

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

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2039 /
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