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

1 PLACE OF DEATH

County Jasper

Township ..... or Village ..... or City Webb City (NO. ..... St.; ..... Ward)

Registration District No. 1417 ~~3021~~ File No. 13051

Primary Registration District No. 3021 Registered No. 58

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

2 FULL NAME John H. Stockinger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June 12 (Month) (Day) 1869 (Year)

7 AGE: 46 yrs. 9 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 108
(b) General nature of industry business, or establishment in which employed (or employer): 85 75

9 BIRTHPLACE (City or town, State or foreign country): Unknown

PARENTS

10 NAME OF FATHER: Jno H Stockinger

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

12 MAIDEN NAME OF MOTHER: Eliza Linch

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chas Reed

(Address) Webb City, Mo.

15 Filed Apr 1, 1915 L. C. Chenaweth Registrar

MEDICAL CERTIFICATE OF DEATH

3

16 DATE OF DEATH: Mar. 30, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 29, 1915, to Mar 30, 1915, that I last saw him alive on Mar 30, 1915, and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Alcoholism + Pneumonia + Epileptic fits

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (Duration) — yrs. — mos. — ds.

(Signed) J. H. Jensen M. D.

Mar 31, 1915 (Address) Quincy 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: Webb City Cem

DATE OF BURIAL: Apr 1, 1915

20 UNDERTAKER: Webb City Und Co

ADDRESS: Webb City Mo.

N. B.—Every item of informa[illegible] [illegible]lly supplied [illegible] should be stated E[illegible] CAUSE OF DEATH in p[illegible] may be properly classified. Exact statement [illegible]

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 *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.)

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper

Township or Village or City Webb City (No. ____ St.; ____ Ward)

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

Registration District No. 417 File No. ____

Primary Registration District No. 3021 Registered No. 58

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

FULL NAME John H. Stockinger

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX M | COLOR OR RACE W | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

DATE OF BIRTH ____ (Month) ____ (Day) 1 (Year)

Satisfactory Information Supplied

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

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

Satisfactory Information Supplied

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

PARENTS
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) ____

Satisfactory Information Supplied

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Filed ____ 191__ ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 (Month) / 30 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw h____ alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

Satisfactory Information Supplied

The CAUSE OF DEATH* was as follows:

Alcoholism & Pneumonia & Epileptic fits.

Lobar Pneumonia

(Duration) ____ yrs. ____ mos. 8 ds.

Contributory (SECONDARY) ____

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

(Signed) J. H. Barton M. D.

June 1, 1915 (Address) Oronogo 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 ____

Satisfactory Information Supplied

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

UNDERTAKER ____ ADDRESS ____

Original file, date APR - - 1915, 19__ All 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.

Revised United States Standard Certificate of Death

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

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