

129 P.

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

PLACE OF DEATH

County Lafayette
Township Lexington
or
Village Lexington
or
City Lexington (NO. _____ St. _____ Ward _____)

Registration District No. 461 File No. 23 13179

Primary Registration District No. 5825 Registered No. _____

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

FULL NAME Joseph F. McQuillen

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 3 1915
(Month) (Day) (Year)

DATE OF BIRTH July 15 1849
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 1st 1915, to March 3, 1915, that I last saw him alive on March 3, 1915, and that death occurred, on the date stated above, at 10:40 a.m.

AGE 62 yrs 7 mos 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Internal Symples from
1915

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

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

(Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Arthur McQuillen

Contributory fall from bridge
(Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) Thompson M. D.
Mar 3 1915 (Address) Lexington MO

MAIDEN NAME OF MOTHER No record

*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) Ireland

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) Ernest Brosche

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

(ADDRESS) Lexington MO

PLACE OF BURIAL OR REMOVAL Dover MO DATE OF BURIAL _____ 191__

Filed P. P. White 1915 J. G. P. White REGISTRAR

UNDERTAKER Julius C. Winkler ADDRESS Lexington MO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. 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, 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 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.)

CAUSE OF DEATH is in plain terms, so that it may be properly classified. Exact names should state transparently.

PLACE OF DEATH

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

County Lafayette Registration District No. 461 File No. _____
Township Lexington Primary Registration District No. 5625 Registered No. 25
Ward _____

FULL NAME

Joseph F McQuillen

[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 _____ WIDOWED _____ OR DIVORCED _____
(Write the word)

DATE OF DEATH _____
March 3, 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 h_____ 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:

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

Internal Injuries
accidental
(Duration) _____ yrs. _____ mos. _____ ds.

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

fall from bridge
Contributory (secondary) (Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER _____

(Signed) B Temple Payne M. D.
3/3 1915 (Address) Lexington

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

MAIDEN NAME OF MOTHER _____

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

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

*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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

(ADDRESS) _____

Filed March 1st 1915 J. L. Coker REGISTRAR

Revised United States Standard Certificate of Death

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

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