

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

1 PLACE OF DEATH  
St. Clair

County .....

Township Doyal

Registration District No. 1005

File No. 13866

or

Village .....

Primary Registration District No. 6009

Registered No. ....

or

City .....

(NO. .... St. .... Ward)

Registered No. ....

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

2 FULL NAME Joseph H. Elliott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH January 16 1861  
(Month) (Day) (Year)

7 AGE 54 yrs. 2 mos. 26 ds. If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS 10 NAME OF FATHER James ELLiott 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Irland 12 MAIDEN NAME OF MOTHER Mary Scott 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Scott Elliott (Address) Collins No.

15 Filed 4/15 1915 Perry W. White Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13 1915  
(Month) (Day) (Year)

17 I, HEREBY CERTIFY, that I attended deceased from April 11, 1915 to April 11, 1915 that I last saw him alive on April 11, 1915 and that death occurred, on the date stated above, at 7 a.m. The CAUSE OF DEATH\* was as follows:

Laryngitis  
(Duration)..... yrs..... mos. 6 ds.  
CONTRIBUTORY Uremic Poisoning (Secondary) (Duration)..... yrs..... mos. 1 ds.  
(Signed) J. J. Mastries M. D. April 15, 1915 (Address) Newmanville, Mo

\*State the Disease Causing Death, or, in death 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 Union Cemetery DATE OF BURIAL 4/14 1915

20 UNDERTAKER J. J. Mastries ADDRESS Oscola Mo

N. B.—Every item of information should be carefully checked. NAME should be stated EXACTLY. PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

# 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 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.)

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

PLACE OF DEATH

County St. Clair  
Township Soyal  
or  
Village  
or  
City

Registration District No. 1005 File No.  
Primary Registration District No. 6009 Registered No.  
(NO. St. Ward)

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

FULL NAME

Joseph N. Elliott

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Apr 13, 1915  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1915,  
that I last saw him alive on \_\_\_\_\_, 1915.  
Satisfactory information supplied.

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

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_

The CAUSE OF DEATH was as follows:

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

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10

BIRTHPLACE  
(City or town, State or foreign country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

Contributory (SECONDARY) acute nephritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) d. J. Duffell M. D.  
4/15, 1915 (Address) Hannibal, Mo.

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)  
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 \_\_\_\_\_ 1915

Filed 4/15, 1915 J. J. White REGISTRAR

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B.—Every item of information in plain terms, so that it can be properly classified. Exact statement of OCCASION is very important.

Satisfactory information supplied.  
SUPPLEMENTARY INFORMATION SUPPLIED.

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