

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<i>Montgomery</i>	Registration District No.	<i>590</i>
Township	<i>Lacrosse</i>	File No.	<i>2 22413</i>
or Village	<i>M. Pittsick</i>	Primary Registration District No.	<i>4348</i>
or City	_____ (NO. _____ St.: _____ Ward)	Registered No.	<i>2</i>
FULL NAME		(If death occurred in a hospital or institution give its NAME instead of street and number)	
<i>Jimmy Yancey</i>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	DATE OF DEATH	
<i>male</i>	<i>Negro</i>	<i>July 2nd 1915</i> (Month) (Day) (Year)	
DATE OF BIRTH	SINGLE MARRIED WIDOWED OR DIVORCED (If not the word)	I HEREBY CERTIFY, that I attended deceased, from	
<i>Unknown, 1896</i> (Month) (Day) (Year)	<i>Single</i>	<i>March 3rd, 1915, to July 27th, 1915,</i>	
AGE	IF LESS than 1 day, _____ hrs. or _____ min.?	that I last saw him alive on <i>July 30th, 1915,</i>	
<i>19</i> yrs. _____ mos. _____ ds.		and that death occurred, on the date stated above, at <i>5 P.</i> m.	
OCCUPATION	The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work	<i>Laborer</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)			
BIRTHPLACE	Tuberculosis of Lungs		
(City or town, State or foreign country)	<i>23h</i>		
<i>Montgomery Co.</i>	<i>78</i>		
PARENTS	Contributory		
NAME OF FATHER	(Secondary)		
<i>Mr. Yancey</i>	(Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE OF FATHER	(Signed) <i>Aug. A. Smith</i> M. D.		
(City or town, State or foreign country)	<i>July 3rd, 1915</i> (Address) <i>Henneman Mrs.</i>		
<i>Warren Co.</i>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
MAIDEN NAME OF MOTHER	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
<i>Mary Horstman</i>	At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE OF MOTHER	Where was disease contracted If not at place of death?		
(City or town, State or foreign country)	Former or usual residence		
<i>Warren Co.</i>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant)	<i>Mr. Yancey</i>		
(ADDRESS)	<i>M. Pittsick</i>		
Filed	<i>July 3 1915</i>		
	<i>J. E. Lamm</i> REGISTRAR		
PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL		
<i>M. Pittsick, Mo.</i>	<i>July 4th, 1915</i>		
UNDERTAKER	ADDRESS		

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*, *Sar-*

coma, 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.)



WRITE PLAINLY, WITH LEADING INK. THIS IS A PERMANENT RECORD.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Montgomery
Township McKittick
Village McKittick
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 590 File No. _____
Primary Registration District No. 4348 Registered No. 2

2 FULL NAME Jimmy Yancy

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE B 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 17 (Month) 1 (Day) 1915 (Year)

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

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

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

PARENTS
10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

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

15 Filed July 8 1915 J. E. Lawrence Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2 1915
(Month) (Day) (Year)

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

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____ 1915 (Address) _____

*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 _____ DATE OF BURIAL _____ 1915

20 UNDERTAKER My Panel ADDRESS McKittick

Original file, date JUL -- 1915

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY INFORMATION Supplied

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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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), *29ds.*; *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.)

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