

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty LewisTownship WaldersonVillage Waldicell

City \_\_\_\_\_

Registration District No. 482Primary Registration District No. 5646File No. 28075

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

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

FULL NAME John Barnett Marchand

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)DATE OF DEATH Sept 4, 1916  
(Month) (Day) (Year)DATE OF BIRTH July 28, 1842  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mar 1, 1915, to Sept 4, 1915, that I last saw him alive on Sept 4, 1915, and that death occurred, on the date stated above, at 6 P. m.AGE 73 yrs. 1 mos. 6 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 Physician (b) General nature of industry, business, or establishment in which employed (or employer) Practice of MedicineNephritis  
121BIRTHPLACE (City or town, State or foreign country) Armstrong County Penn.(Duration) 1 yrs. \_\_\_\_ mos. \_\_\_\_ ds.NAME OF FATHER George W. Marchand

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) Westmoreland County Penn.(Signed) Geo. P. Knight M. D.MAIDEN NAME OF MOTHER Isabella KerrSept 6, 1915 (Address) WaldicellBIRTHPLACE OF MOTHER (City or town, State or foreign country) Westmoreland County Penn.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Informant) W. H. Marchand

Where was disease contracted If not at place of death? \_\_\_\_\_

(ADDRESS) Waldicell Mo

Former or usual residence. \_\_\_\_\_

Filed Sept 6, 1916 - Geo P Knight REGISTRARPLACE OF BURIAL OR REMOVAL Waldicell Mo DATE OF BURIAL Sept 5, 1916UNDERTAKER Thomas Ball ADDRESS Ewing

# 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.<sup>4</sup> 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.)

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Lewis  
 Township Dickerson  
 or  
 Village  
 or  
 City

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

Registration District No. H 82 File No.  
 Primary Registration District No. 5646 Registered No.

2 FULL NAME

John Barrett Marchand

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Sept. 15, 1915  
 (Month) (Day) (Year)

6 DATE OF BIRTH factory information supplied (Day) 1 (Year)

17 I HEREBY CERTIFY, that I attended deceased from factory information supplied to factory information supplied, 1915.  
 that I last saw him factory information supplied alive on factory information supplied, 1915.

7 AGE factory information supplied yrs. mos. If LESS than 1 day, hrs. or min.?

and that death occurred, on the date stated above, at factory information supplied m.  
 The CAUSE OF DEATH\* was as follows:

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

Chronic Nephritis  
150  
 (Duration) yrs. mos. ds.

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

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

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)

(Signed) Geo. W. Knight M. D.  
9-6, 1915 (Address) Monticello

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

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

15 Filed Oct 26, 1915 - Geo. W. Knight Registrar

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 factory information supplied, 1915  
 20 UNDERTAKER ADDRESS

SUPPLEMENTARY INFORMATION SUPPLIED

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