

## PLACE OF DEATH

County Jefferson  
 Township W 42  
 or  
 Village Byersville  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 425 File No. 3  
 Primary Registration District No. 6580 Registered No. 10856

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

FULL NAME James J. Parkinson

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	<del>SINGLE</del> <del>MARRIED</del> <del>WIDOWED</del> <del>OR DIVORCED</del> (Write the word) <u>Single</u>
DATE OF BIRTH <u>April 8, 1898</u> (Month) (Day) (Year)		
AGE <u>27</u> yrs. <u>10</u> mos. <u>23</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE  
(City or town, State or foreign country)  
Hillsboro, MoNAME OF FATHER  
Thomas ParkinsonBIRTHPLACE OF FATHER  
(City or town, State or foreign country)  
Pa. U.S.A.MAIDEN NAME OF MOTHER  
Henrietta G. LittleBIRTHPLACE OF MOTHER  
(City or town, State or foreign country)  
New Albany, Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Octavia Buchanan(ADDRESS) Byersville, Mo.Filed Mar 3 1916 Chas. Williams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
March 1, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 14, 1916, to March 1, 1916, that I last saw him alive on March 1, 1916, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

107A  
Pneumonia,  
16 days.  
 (Duration) \_\_\_ yrs. \_\_\_ mos. 16 ds.

Contributory  
(SECONDARY)  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.(Signed) John F. Roepers M. D.  
191\_\_\_ (Address) Byersville, 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.

PLACE OF BURIAL OR REMOVAL  
Hillsboro, Mo. DATE OF BURIAL  
Mar. 3, 1916UNDERTAKER  
E. A. Stovwand ADDRESS  
Cedar Hill, Mo.

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.

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County \_\_\_\_\_  
 Township \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 or Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
(Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 IF LESS than  
 1 day 1 hr. \_\_\_\_\_  
 1 mos. \_\_\_\_\_ ds. \_\_\_\_\_ of \_\_\_\_\_ min. ?

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (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. The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_ REGISTRAR \_\_\_\_\_

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.

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.

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

1 PLACE OF DEATH  
 County Jefferson REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW  
 Township Meramec Registration District No. 475 File No. ....  
 or  
 Village ..... Primary Registration District No. 5580 Registered No. 8  
 or  
 City (NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James G. Parkinson

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH  
 (Month) (Day) 1 (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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 / 16 1916  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 3/16 1916 to 3/16 1916  
 the I last saw h. alive on 3/16 1916  
 and that death occurred, on the date stated above, at 3-1-16 m.  
 The CAUSE OF DEATH\* was as follows:  
Emphysema Pneumonia  
 (Duration) 9 yrs. 16 mos. 16 ds.  
 CONTRIBUTORY (Secondary) .....  
 (Duration) ..... yrs. .... mos. .... ds.  
 (Signed) John H. Prosser M.D.  
3-1-16 (Address) Baltimore, Md.

\*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 Hillman, Mo DATE OF BURIAL Mar 24 1916  
 20 UNDERTAKER E. A. Shover and ADDRESS Rock Hill Mo

SUPPLEMENTARY

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Octavia Buchanan  
 (Address) Byrnsville, Mo

15 Filed Mar 21 1916 Chas. Williams Registrar

# 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*, *Composer*, *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), 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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