

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

PLACE OF DEATH

County Pettis
Township Washington Registration District No. 664 File No. 11491
or
Village Green Ridge Primary Registration District No. 5883 Registered No. 103
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME James W. Harkless

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov 23, 1850
(Month) (Day) (Year)

AGE 66 yrs. 88 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Born in Ohio

PARENTS
NAME OF FATHER _____
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) J. W. Harkless
(ADDRESS) Green Ridge mo.
Filed Nov 14, 1916 D. H. Clabaugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March the 11, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March, 1916, to Mar 11, 1916, that I last saw him alive on Mar 8, 1916, and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

82D Paralysis
(Duration) 4 yrs. 10 mos. 10 ds.
Contributory Paralysis
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) D. W. Clabaugh M. D.
1916 (Address) Green Ridge

*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 40 yrs. _____ mos. _____ ds. In the State 40 yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? at place of work
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Antioch Cemetery DATE OF BURIAL March 12, 1916
UNDERTAKER J. R. Shelly ADDRESS Green Ridge 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.

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), *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.)

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

1 PLACE OF DEATH

County *Lettis*
Township *Washington*
Village
City

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

Registration District No. *664* File No.
Primary Registration District No. *5883* Registered No. *103*

(NO. St. Ward)

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

2 FULL NAME

James W. Nankless

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *wid*
6 DATE OF BIRTH (Month) (Day) (Year)
7 AGE 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) *A*

10 NAME OF FATHER *Procutt Nankless*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *19.4*
12 MAIDEN NAME OF MOTHER *Callie Matheis*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *12.4*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *J. W. Nankless* (Address) *Grew Ridge Mo*

15 Filed *3/14 6* 1916 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Me 11 6* 1916 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ... 191... to ... 191... that I had seen him alive on ... 191... and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH was as follows: *Paralysis*
(Duration) yrs. *4* mos. *10* ds.

CONTRIBUTORY (Secondary) *Paralysis*
(Duration) yrs. mos. ds.
(Signed) *D. W. Clough* M. D.
Aug 8 1916 (Address) *Wrensbidge*

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 1916

20 UNDERTAKER ADDRESS

DIAGONAL STAMP: SUPPLEMENTARY INFORMATION SUPPLIED

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

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1911
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