N. B.—Every item [illegible] carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DE[illegible] it may be properly classified. Exact statement of OCCUPATION is very important.

DING INK—THIS IS A PERMANENT RE[illegible]RD

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

15456

PLACE OF DEATH

County: Pettis

Township: _____ or Village: _____ or City: Sedalia (NO. Boonville & Brown St.; _____ Ward)

Registration District No. 668

Primary Registration District No. 3032

File No. Morley

Registered No. 103

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

FULL NAME John T. Stotts

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 12 (Day), 1847 (Year)

AGE: 69 yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS

NAME OF FATHER: Frank Stotts

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ken.

MAIDEN NAME OF MOTHER: Maragut Ricks

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ken.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs N. J. Bellows

(ADDRESS) Sedalia Mo

Filed April 10 1916. F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 9 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from April 9, 1916, to April 9, 1916, that I last saw him alive on April 9, 1916, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

82D

118C acute indigestion

_____ (Duration) _____ yrs. _____ mos. 1/2 ds.

Contributory (SECONDARY) Paralysis

_____ (Duration) 3 yrs. _____ mos. _____ ds.

(Signed) Frank R Morley M. D.

8 April 10 1916 (Address) Sedalia 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: Sedalia Mo

DATE OF BURIAL: 4-10 1916

UNDERTAKER: McLaughlin

ADDRESS: Sedalia

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

PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

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) ....., 1..... (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

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) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (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:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

..... (Duration) .....yrs. .....mos.

(Signed) ..... M.D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, (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. .....

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**

—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classi-

Dr. Morley

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

1 PLACE OF DEATH

County Pettis

Township ..... or Village ..... or City Sedalia (No. ..... St., ... Ward)

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

Registration District No. 668 File No. .....

Primary Registration District No. 3032 Registered No. 103

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

2 FULL NAME John. T. Stotts

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) .....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed 4/10, 1916 F. B. Long Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4/9, 1916 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 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:

Acute Indigestion

Possibly acute Gastritis

(Duration) 64 yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Paralysis (Paraplegia)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank R Morley M. D.

4/10, 1916 (Address) Sedalia

*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 ..... 191...

20 UNDERTAKER ..... ADDRESS .....

SUPPLEMENTARY

Satisfactory Information Supplied

Original file, date ..... 1916, 19.....

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

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

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, 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 *septichaemia,*" "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.)