

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

PLACE OF DEATH

County Jasper

Township [blacked out]

Village [blacked out]

City Joplin

Registration District No. 711

File No. 18231

Primary Registration District No. 2002

Registered No. 288

(NO. 506 E 9th)

St.: _____ Ward)

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

FULL NAME James B Brewer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 9, 1916
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. 3 mos. 27 ds.

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

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

NAME OF FATHER Virgil H Brewer

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

MAIDEN NAME OF MOTHER Sarah Hamilton

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V H Brewer
(ADDRESS) 506 E 9th St

Filed 5-6 1916 R. M. Yagg
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 5, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 25, 1916, to May 5, 1916, that I last saw him alive on May 3rd, 1916, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Mesenteric Occurred

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

Contributory (SECONDARY) Cummins
(Duration) _____ yrs. _____ mos. 20 ds.

(Signed) Uptonshaw M.D.
May 5, 1916 (Address) 516 Main St

*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 _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Pitching Mo DATE OF BURIAL May 6, 1916

UNDERTAKER Cunningham ADDRESS Joplin

WRITE PLAINLY, WITHOUT ENFADING

N. B.—Every item of information should be carefully supplied. AGE should be stated in EXACT YEARS. PHYSICIANS should state CAUSE OF DEATH in plain English. It may be properly classified in the Department of OCCUPATION is very important.

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

PLACE OF DEATH

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____) _____ St. _____ Ward _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

(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 OR DIVORCED (If wife, the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)	AGE _____ yrs. _____ mos. _____ ds.	
AGE _____	IF LESS than 1 day, _____ hrs. or _____ min.?	

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

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

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) _____ (Year), 191____

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 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____, 191____ (Address) _____ M. D.

*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. 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 _____

1 PLACE OF DEATH

County Jasper
Township Joplin
Village Joplin
City Joplin

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

Registration District No. 411 File No. 2002
Primary Registration District No. 288 Registered No. 288

2 FULL NAME James B Brewer

(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 W. 5 SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)

6 DATE OF BIRTH 1 (Month) 1 (Day) 1916 (Year)

7 AGE 37 yrs. 1 mo. 1 da. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Satisfactory Information Supplied

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

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

15 Filed May 6, 1916 A. M. Greig Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 (Month) 5 (Day) 1916 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1916 to 1916, that I last saw him alive on 5, 1916, and that death occurred, on the date stated above, at 5/5 m. The CAUSE OF DEATH* was as follows: Satisfactory Information Supplied

Scholar Pneumonia
(Duration) 10 yrs. 10 mos. 20 da.

CONTRIBUTORY Pneumonia (Secondary)
(Duration) 10 yrs. 10 mos. 20 da.
(Signed) A. W. Horsham M. D.
515 1916 (Address) 516 Main St.

*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 10 yrs. 10 mos. 20 da. In the State 10 yrs. 10 mos. 20 da.
Where was disease contracted if not at place of death? Satisfactory Information Supplied
Former or usual residence Satisfactory Information Supplied

19 PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied DATE OF BURIAL 1916

20 UNDERTAKER Satisfactory Information Supplied ADDRESS Satisfactory Information Supplied

PINK-THE A PERMANENT RECORD

N. B.—Every item of information with a full name, age, sex, occupation, etc., should state EXACTLY PHYSICIANS should state statement of OCCUPATION is very important.

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

10231

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.)