

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

1 PLACE OF DEATH

County *Copper*
Township *Pilot Grove*
or
Village
or
City

Registration District No. *242*

File No.

20830

Primary Registration District No. *5303*

Registered No.

(NO.

St.

Ward)

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

2 FULL NAME

James S. Brownfeld

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Aug 23 1844
(Month) (Day) (Year)

7 AGE

71 yrs 9 mos 13 ds.

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

8 OCCUPATION

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

Farmer

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

9 BIRTHPLACE

(City or town,
State or foreign country)

Pettis Co Mo

10 NAME OF
FATHER

Thomas Brownfield

11 BIRTHPLACE
OF FATHER

Virginia

12 MAIDEN NAME
OF MOTHER

Elizabeth Evans

13 BIRTHPLACE
OF MOTHER

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R O Brownfeld

(Address)

Pilot Grove, Mo.

15

Filed

June 7 1916 J. O. Suddler

Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 6 1916
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

June 1 1916 to June 6 1916

that I last saw him alive on *June 6 1916*

and that death occurred, on the date stated above, at *1:15 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

82.A

97

(Duration) *6* mos. *2* ds.

CONTRIBUTORY

(Secondary)

(Duration) *7* yrs. *6* mos. *2* ds.

(Signed) *Thomas B. Todd* M. D.

June 6 1916 (Address) *Pilot Grove Mo*

*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 *71* yrs. *9* mos. *13* ds. In the State *71* yrs. *9* mos. *13* ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Vernon June 8 1916

20 UNDERTAKER

ADDRESS

Edcott Chapman Pilot Grove Mo

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. 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

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

1 PLACE OF DEATH
County Copple
Township Pilot Grove
or
Village
or
City

Registration District No. 222 File No. 8
Primary Registration District No. 5303 Registered No.
(NO. St. Ward)

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

2 FULL NAME

Jonas H. Brownfield

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH June 6, 1916
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from
191 to 191
that I last saw him on 191
and that death occurred, on the date stated above, at

7 AGE
yrs. mos. ds. If LESS than
1 day hrs. or min.?

The CAUSE OF DEATH* was as follows:

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

Cerebral Hemorrhage
Arterio Sclerosis
(Duration) yrs. mos. ds.

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

CONTRIBUTORY Arterio Sclerosis
(Secondary)

10 NAME OF FATHER

(Signed) T. O. Cuddeback M. B. A.

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

6-6, 1916 (Address) Pilot Grove, Mo.

12 MAIDEN NAME OF MOTHER

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant)

Where was disease contracted
if not at place of death?

(Address)

Former or usual residence.

15

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Filed Aug 7, 1916 T. O. Cuddeback

20 UNDERTAKER ADDRESS

Registrar

Original file, date JUN 1916

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

Revised United States Standard Certificate of Death

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

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