

RECORD

WRITE PL

Physicians should state CAUSE OF DEATH in P

Every item of Inform

PLACE OF DEATH

County St. Francois
 Township Randolph
 or
 Village Desloge
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 779 File No. 31
 Primary Registration District No. 6034A Registered No. 32245

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

FULL NAME William Edward Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Nov. 26</u> , 19 <u>15</u> <small>(Month) (Day) (Year)</small>		
AGE <u>0</u> yrs. <u>8</u> mos. <u>7</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 3, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 11, 1916, to Aug. 30, 1916, that I last saw him alive on Aug. 30, 1916, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:
Transition

BIRTHPLACE
 (City or town, State or foreign country) Desloge Mo.

PARENTS	NAME OF FATHER <u>William Jones</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>
	MAIDEN NAME OF MOTHER <u>Rosa Burt</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>

(Duration) _____ yrs. 6 mos. _____ ds.

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

(Signed) R. B. Bester M. D.
Sept. 3, 1916. (Address) Desloge Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Wm Jones

(ADDRESS) Desloge Mo
 Filed Sept 3, 1916, Gwerson REGISTRAR

*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 Gwerson Cemetery DATE OF BURIAL Sept 4, 1916
 UNDERTAKER Ed Rinde ADDRESS Ed at River

PLACE OF DEATH

County _____

Township _____

or

Village _____

-or-

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 OR MARRIED OR DIVORCED (Specify the word)
DATE OF BIRTH _____	(Month) _____	(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)

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 _____ REGISTRAR

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

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:

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

Contributory (SECONDARY) _____ yrs. _____ mos. _____ ds.

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

_____ M. D.
 (Address) _____

* 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 _____

PHYSICIAN'S (Should be filled in by physician)
 OCCUPATION _____

NT RECORD

WR

No. 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. ETHNICGIANS should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important.

1 PLACE OF DEATH

County *St. Francois*
 Township *Randolph*
 or
 Village
 or
 City (NO.) (St.) (Ward ..)

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

Registration District No. *779* File No. *32245*
 Primary Registration District No. *60 year* Registered No.

2 FULL NAME

William Edward Jones

(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) *S*

6 DATE OF BIRTH 191... (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)

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 *Sept 3* 191*6* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 3* 191*6* (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191... to 191... that I last saw him/her alive on 191... and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: *Supplied*

Insultion
Failure since birth to digest & assimilate any food.
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *W. E. Jones M.D.* M. D. *Sept 3, 1916* (Address) *Delevoy 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 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 Information Supplied. SUPPLEMENTARY INFORMATION SUPPLIED.

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 "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "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.)