

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

PLACE OF DEATH
County Douglas
Township _____
or
Village _____
or
City Ava (NO. _____) St.; _____ Ward)

Registration District No. 272 File No. 769
Primary Registration District No. 4165 Registered No. 6

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

FULL NAME John J Meek

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>June 13 1861</u> <small>(Month) (Day) (Year)</small>		
AGE <u>55</u> yrs. <u>7</u> mos. <u>7</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Common Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Arkansas</u>		
PARENTS	NAME OF FATHER <u>Charley Meek</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Paxton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Jan 21 1917</u> <small>(Month) (Day) (Year)</small>	
I HEREBY CERTIFY, that I attended deceased from <u>Jan 15</u> , 1917, to <u>Jan 20</u> , 1917, that I last saw him alive on <u>Jan 20</u> , 1917, and that death occurred, on the date stated above, at <u>4 a</u> m.	
The CAUSE OF DEATH* was as follows: <u>Labor Exhaustion</u> <u>106</u> <u>92</u> <small>(Duration) ___ yrs. ___ mos. ___ ds.</small>	
Contributory <small>(SECONDARY)</small> <small>(Duration) ___ yrs. ___ mos. ___ ds.</small>	
(Signed) <u>R M Thomas</u> M. D. <u>Jan 26 1917</u> (Address) <u>Ava Mo</u>	
*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 _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah C Meek
(ADDRESS) Ava Mo

Filed Jan 20 1917
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Ava Cemetery
DATE OF BURIAL
Jan 21 1917
UNDERTAKER
Neighbors
ADDRESS

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.)

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
St. Louis
Country.....
Township.....
or
Village.....
or
City..... *awa*

Registration District No. *272* File No.
Primary Registration District No. *465* Registered No. *6*
(NO. St. Ward)

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

2 FULL NAME *John J. Meek*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m* 4 COLOR OR RACE *w* 5 SINGLE MARRIED WIDOWED OR DIVORCED *m*
(Write the word)

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 *Jan 30* 1917 *J. W. Osborn* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 30* 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
that I last saw him 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..... ds.
(Signed)..... M. D.
..... 191..... (Address).....

*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

Revised United States Standard Certificate of Death

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

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