

RECORDING 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 Pike
Township _____
or _____
Village _____
or _____
City Bowling Green Mo (NO. _____) St. _____ Ward _____

Registration District No. 684 File No. 15834
Primary Registration District No. 4408 Registered No. 24

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

FULL NAME Joseph Henry Jackson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
DATE OF BIRTH November 6, 1916
(Month) (Day) (Year)
AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
5 yrs. 13 mos. 13 ds.

DATE OF DEATH April 19, 1917
(Month) (Day) (Year)

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

I HEREBY CERTIFY, that I attended deceased from 4/17, 1917, to 4/19, 1917, that I last saw him alive on 4/17, 1917, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH was as follows:
18 meningitis

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

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

NAME OF FATHER Henry Jackson

Contributory Influenza
(SECONDARY) (Duration) _____ yrs. _____ mos. 8 ds.

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

(Signed) T. H. Strickman M. D.
4/20, 1917 (Address) Bowling Green

MAIDEN NAME OF MOTHER Bessie Hall

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jess Hall

Where was disease contracted if not at place of death? _____
Former or usual residence _____

(ADDRESS) Bowling Green Mo

PLACE OF BURIAL OR REMOVAL Bowling Green Cemetery DATE OF BURIAL April 20, 1917

Filed 4/20 1917 T. H. Strickman REGISTRAR

UNDERTAKER Timley & Banthead ADDRESS Bowling Green Mo

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)

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

Part 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.

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (write the word)
DATE OF BIRTH	(Month) _____, 191____	(Day) _____, 191____ (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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (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^r was as follows:

PARENTS

BIRTHPLACE OF FATHER (City or town, State or foreign country)	BIRTHPLACE OF MOTHER (City or town, State or foreign country)
NAME OF FATHER	NAME OF MOTHER
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant)	

CONTRIBUTORY (SECONDARY)

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

(Address) _____, 191____ 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
UNDERTAKER	ADDRESS

Filed _____, 191____ REGISTRAR _____

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Boone

Township _____

or Village _____

or City Bowling Green

Registration District No. 684

File No. _____

Primary Registration District No. 4408

Registered No. 24

2 FULL NAME

Joseph Henry Jackson

(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 B 5 SINGLE MARRIED WIDOWED OR DIVORCED 2
(Write the word)

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

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

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 4/30 1917 J. H. [Signature]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 19 1917
(Month) _____ (Day) _____ (Year) _____

17 I HEREBY CERTIFY, that I attended deceased from _____ 1917 to _____ 1917,
that I last saw him _____ alive on _____ 1917,
and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows: Epidemic Meningitis
6 W
Duration) _____ yrs _____ mos _____ ds.

CONTRIBUTORY (Secondary) Jackson
(Duration) _____ yrs _____ mos _____ ds.
(Signed) _____ M. D.
4/30 1917 (Address) _____

*State the Disease Causing Death, or, in death 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 _____ 1917

20 UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information should be carefully supplied; AGE should be stated EXACTLY, IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION, TRADE, PROFESSION, BUSINESS, or ESTABLISHMENT IN WHICH EMPLOYED, WITH UNFADING INK—FEE IS A FURNISHED BY RECORD

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

15834

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*, *Composer*, *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 "Asthemia," "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.)