

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Barry

Township \_\_\_\_\_

Village \_\_\_\_\_

City Monett (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 30

Primary Registration District No. 3003

File No. 17660

Registered No. 33

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

2 FULL NAME Thomas Curry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married  
(If write the word)

6 DATE OF BIRTH Feb. 8 1853  
(Month) (Day) (Year)

7 AGE 62 yrs. 2 mos. 2 da. If LESS than 1 day, hrs. or min.?

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

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

PARENTS 10 NAME OF FATHER Joe Curry  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know  
12 MAIDEN NAME OF MOTHER Don't know  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. E. Vinson  
(Address) Monett Mo

15 Filed 5-4-1917 J. M. King  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 30, 1917, to May 4, 1917, that I last saw him alive on May 3, 1917, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH\* was as follows:  
Peritonitis  
Intestinal perforation  
136  
123A (Duration) 14 yrs. 11 mos. 14 da.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
(Signed) Alva Jones M. D.  
May 4, 1917 (Address) Monett, 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. \_\_\_\_\_ da. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Catholic Cem DATE OF BURIAL May 6, 1917

20 UNDERTAKER J. M. King ADDRESS Monett 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*, *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), *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.)

1 PLACE OF DEATH

County Bany  
 Township  
 or  
 Village Monett  
 or  
 City

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

Registration District No. 30  
 Primary Registration District No. 3003

File No. 17660

Registered No.

(NO. St. Ward)

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

2 FULL NAME Thos. Jas. Curny

PERSONAL AND STATISTICAL PARTICULARS

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

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

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 6-8- 1918 J. H. West Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) May 7 1917

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) 191 to (Month) (Day) (Year) 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: Lentoxenia Alcoholic Intestinal perforation caused prof. Dysentery (Duration) yrs.....mos.....ds.

CONTRIBUTORY (Secondary) (Duration) yrs.....mos.....ds. Signed Alva Jones M. D. June 8, 1918 (Address) Monett, 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

# Revised United States Standard Certificate of Death

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

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