

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

PLACE OF DEATH

County Montgomery
Township Deer Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 179
Primary Registration District No. 1794 a

File No. 19352
Registered No. 96

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

FULL NAME Eddie Wells

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Negro</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH _____, 19____, to _____, 19____ (Month) (Day) (Year)		
AGE <u>24 yrs. 11 mos. 8 ds.</u>		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm laborer</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Montgomery Co MO</u>		
PARENTS	NAME OF FATHER <u>John Ed wells</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Montgomery Co Mo</u>	
	MAIDEN NAME OF MOTHER <u>Addie Better</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 26, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Accidental - Struck by lightning

(Duration) 180 yrs. ____ mos. ____ ds.

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

(Signed) B. F. Manette Corcoran M. D.
May 26, 1917 (Address) Montgomery City, Mo

*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) Henry Davis
(ADDRESS) _____

Filed _____, 19____, _____
REGISTRAR

PLACE OF BURIAL OR REMOVAL Jonesburg MO
DATE OF BURIAL May 27, 1917
UNDERTAKER 33 Stephens Jonesburg MO
ADDRESS _____

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.....)

Registration District No.

Primary Registration District No.

File No.

Registered 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 MARRIED WIDOWED OR DIVORCED (Write the word)
	DATE OF BIRTH	(Month)....., 191.....	(Day)....., 191.....
AGEyrs.,.....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

191.....

REGISTRAR

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* 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.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place.....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.....

UNDERWRITER

ADDRESS

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 Montgomery
 Township Burlington
 or
 Village
 or
 City (NO.) St. Ward

Registration District No. 589 File No.
 Primary Registration District No. 589 Registered No.

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

2 FULL NAME Eddie Wells

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH June 18 1890
 (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 July 11 1917 Registrar J. Foreman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 26 1917
 (Month) (Day) (Year)

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

The CAUSE OF DEATH* was follows:

(Duration) yrs mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs mos ds. (Signed) M. D. 191 (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 191

20 UNDERTAKER ADDRESS

Revised United States Standard Certificate of Death

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

2567
1934

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 inter-current) 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 "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.)