

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

PLACE OF DEATH
County Jasper
Township Creston
Village _____
City _____

Registration District No. 410 File No. _____
Primary Registration District No. 5566 Registered No. 26

FULL NAME William R. Farris (NO. _____ St. _____ Ward _____)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH 1st 23 1843
(Month) (Day) (Year)

AGE 74 yrs. 7 mos. 4 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER Reuben R. Farris
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
MAIDEN NAME OF MOTHER Elizabeth Bradwater
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. G. Sluder

(ADDRESS) Lamar, Mo.

Filed Aug 28 1917 DW Teeter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 27, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 4, 1917, to Aug 27, 1917, that I last saw him alive on Aug 24, 1917, and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH was as follows:

Heart disease

97 1/2 (Duration) ____ yrs. ____ mos. ____ ds.

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

(Signed) V. H. Hendricks M. D.
Aug 28, 1917 (Address) Jasper, 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 _____

PLACE OF BURIAL OR REMOVAL Lamar, Mo. DATE OF BURIAL Aug 30 1917

UNDERTAKER Hosp. Humphrey ADDRESS Lamar, Mo.

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 hospital or institution, give its NAME inside 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) _____ (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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____, 191 _____

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 _____.

The CAUSE OF DEATH* was as follows: _____

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

Contributory
(SECONDARY)

(Signed) _____ (Address) _____ M. D. _____
 _____ 191 _____

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

*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 _____ DATE OF BURIAL _____, 191 _____

UNDERTAKER _____ ADDRESS _____

PARENTS

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 _____

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 Jasper
Township Boston
or
Village
or
City

Registration District No. 410 File No.
Primary Registration District No. 5566 Registered No. 26

(NO. St. Ward)

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

2 FULL NAME William R. Farr

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) 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 Aug 28, 1917 J.W. Peeler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) Aug 27 1917

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) 191 to (Month) (Day) (Year) 191 that I last saw him alive on (Month) (Day) (Year) 191 and that death occurred, on the date stated above.

The CAUSE OF DEATH* was as follows: Heart Dis. Resurgitation

(Duration) 79 yrs. mos. ds. CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W. H. Hendricks M. D. Aug 28, 1917 (Address) Jasper 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 (Duration) yrs. mos. ds. In the State (Duration) 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 Aug 30, 1917

20 UNDERTAKER 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*, *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 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.)

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