

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**

**1 PLACE OF DEATH**

County Phelps  
 Township \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City St James (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 678 File No. 652767  
 Primary Registration District No. 440X Registered No. \_\_\_\_\_

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

**2 FULL NAME** J R Faulkner

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Male **4 COLOR OR RACE** white **5 SINGLE MARRIED WIDOWED OR DIVORCED** Married  
(Write the word)

**6 DATE OF BIRTH** Oct 7 1886  
(Month) (Day) (Year)

**7 AGE** 30 yrs 11 mos 16 ds. **If LESS than 1 day.....hrs. or.....min.?**

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Minister  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE**  
 (City or town, State or foreign country) Phelps co Mo

**PARENTS**

**10 NAME OF FATHER** Riley Faulkner

**11 BIRTHPLACE OF FATHER**  
 (City or town, State or foreign country) Dont Know

**12 MAIDEN NAME OF MOTHER** Leimma Cooper

**13 BIRTHPLACE OF MOTHER**  
 (City or town, State or foreign country) Dont Know

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) L Westlake  
 (Address) st James mo

**15** Filed Sept-24 1917 Wm. Florence Hatlock  
 Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Sept 23 1917  
(Month) (Day) (Year)

**17 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 1020 m.

**The CAUSE OF DEATH\* was as follows:**  
Typhoid Fever

(Duration) 11 yrs..... mos..... ds.

**CONTRIBUTORY**  
 (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs..... mos..... ds.  
 (Signed) C. C. Greenfield M. D.  
Sept 23 1917 (Address) St James mo

\*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** asher cem **DATE OF BURIAL** 9-28 1917

**20 UNDERTAKER** W. E. Richler **ADDRESS** st James 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*, *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, 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.)

**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 Shelby  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City James (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 678 File No. \_\_\_\_\_  
Primary Registration District No. 4404 Registered No. 61

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

FULL NAME John Riley Faulkner

**PERSONAL AND STATISTICAL PARTICULARS**

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

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) \_\_\_\_\_

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16 DATE OF DEATH Apr 23 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: \_\_\_\_\_

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) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
\_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

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18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
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Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_

15 Filed Nov. 8 1917 Mr. Florence W. Hall Registrar

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY INFORMATION SUPPLIED BY Informant

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