

PLACE OF DEATH

MISSOURI STATE BUREAU OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Scott
Township Morley
or
Village Morley
or
City _____ (NO. _____ St. _____ Ward _____)Registration District No. 819
Primary Registration District No. 6068File No. 23746-11
Registered No. ~~_____~~

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

FULL NAME

James Henry Graves

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED Widower WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH March - 25 - 1867
(Month) (Day) (Year)AGE 50 yrs. 6 mos. X 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) XBIRTHPLACE (City or town, State or foreign country) New Madrid Co. - Mo.NAME OF FATHER John Riley GravesBIRTHPLACE OF FATHER (City or town, State or foreign country) TennesseeMAIDEN NAME OF MOTHER Mary MorrowBIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis R. Graves(ADDRESS) Advance Mo.

Filed _____ 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH September 23, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Sept. 9 -, 1917, to Sept. 21, 1917, that I last saw him alive on Sept. 21 -, 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease131 (Duration) 9 yrs. ____ mos. ____ ds.Contributory abdominal distension
(SECONDARY) (Duration) ____ yrs. 5 mos. ____ ds.(Signed) E. D. Harris M. D.
Sept 24, 1917 (Address) Morley 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 Hickory Grove DATE OF BURIAL Sept. 24, 1917UNDERTAKER Combs & Sons ADDRESS Morley Mo.

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

Revised United States Standard Certificate of Death

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

MISSOURI STATE
BUREAU OF VITALS
CERTIFICATE

Statement of occupation.—Precise statement of occupation is very important, so that the relative

County _____
 Township _____ or Village _____ or City _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered _____
 (NO.) _____ St. _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
 COLOR OR RACE _____
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 IF LESS than 1 day, _____ hrs. _____ min.?
 or _____ mos. _____ ds.
 AGE _____ yrs. _____ mos. _____ ds.

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 _____

DATE OF DEATH _____
 (Month) _____

I HEREBY CERTIFY, that _____, 191____, to _____, that I last saw him _____ alive on _____ and that death occurred, on the _____ day of _____, 191____, that the CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY) _____
 (Signed) _____ (Duration) _____
 (Signed) _____ (Duration) _____

* State the Disease Causing Death, or, in (1) Means of Injury, and (2) whether Accident.
 LENGTH OF RESIDENCE (FOR HOSPITAL RECENT RESIDENTS) _____
 At place of death _____ yrs. _____ mos. _____ ds. _____
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____
 UNDERTAKER _____

"Typhoid pneumonia"; *Lobar pneumonia*; *Broncho-pneumonia* ("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 intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death),

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

1. PLACE OF DEATH

County Scott Registration District No. 819 File No.
 Township Morley Primary Registration District No. 6068 Registered No.
 City (No.) St. Ward)

2. FULL NAME

(a) Residence. No. James Henry Grant St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Louis R Grant (Address) Advance Mo

15. FILED 9-26-19-17 Mrs. W. Trisler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1917

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... (that I last saw him alive on 19....., 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.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Hickory Grove Cem Sept 24 1917

20. UNDERTAKER ADDRESS C. M. Gipton Morley Mo

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

SUPPLEMENTARY
 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS

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, 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 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

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