

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

PLACE OF DEATH

County Pettis

Registration District No. 668

File No. 42252

Township

Village

Primary Registration District No. 3032

Registered No. 997

City Sedalia (NO. _____ St.: _____ Ward)

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

FULL NAME Rufus Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED married
(If write the word)

DATE OF BIRTH Sept - 3 - 1882
(Month) (Day) (Year)

AGE 65 yrs. -3 mos. - ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) N Y

NAME OF FATHER Matthew Johnson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Vermont

MAIDEN NAME OF MOTHER Kath Perrington

BIRTHPLACE OF MOTHER (City or town, State or foreign country) N Y

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Staley Wood Co

(ADDRESS) Sedalia

Filed Dec 19 1917 F B Long

REGISTRAR W. C. J. Deputy

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 17, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 16, 1917, to Dec 17, 1917, that I last saw him alive on Dec 17, 1917, and that death occurred, on the date stated above, at 10.45 m. The CAUSE OF DEATH* was as follows:

Tetanus
194B
75B
(Duration) ___ yrs. ___ mos. ___ ds.

36 Contributory Injury to back of hand
(Secondary) alcohol (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) F B Long M. D.
Dec 19 1917 (Address) Sedalia

*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 Burton mo DATE OF BURIAL 12/19 1917

UNDERTAKER Staley Wood Co ADDRESS Sedalia

PLACE OF DEATH.

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

County.....
 Township..... Registration District No. File No.
 or Village..... Primary Registration District No. Registered No.
 or City..... (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)	(Day)
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)

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) (Day) 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to 191.....,

that I last saw h..... alive on

and that death occurred, on the date, stated above, at

The CAUSE OF DEATH* was as follows:

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

Contributory

(SECONDARY)

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

(Signed)

..... (Address)

M. D.

*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. 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

1 PLACE OF DEATH

County

Township

Village

City

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.: Ward)

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

2 FULL NAME

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.?

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 *Feb 6, 1918**J. B. Long**per E. T. Deputy*

Original file, date....., 19.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(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:

~~Septicemia~~
Septicemia due to Staphylococcus
infection
accidental
1918
(Duration)..... yrs..... mos..... da.

CONTRIBUTORY

Injury to back of hand
(Alcoholism) (Drugs) (Overexertion) (Got corn at work)
(Signed) *Frank R. Morley* M. D.
Feb 6, 1918 (Address) *Sedalia, 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..... 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

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

25221

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 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 "Asthena," "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.)