

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

1 PLACE OF DEATH

County Leola

Township..... Registration District No. 213- File No. 4650
or.....

Village..... Primary Registration District No. 3014- Registered No. 20-
or.....

City Jefferson (NO. 210, Jefferson St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Miller

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Dec. 13, 1833
(Month) (Day) (Year)

7 AGE yrs. mos. ds. If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Penn.

PARENTS 10 NAME OF FATHER Peter Miller
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
12 MAIDEN NAME OF MOTHER Elisabeth Maus
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) E. J. Miller
(Address) Jefferson City Mo.

15 Filed Feb. 5, 1918 Debra Jones Registrar

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Feb. 5, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 2-1, 1918, to 2-5, 1918

that I last saw him alive on 2-5, 1918 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

9 2 1/2
(Duration)..... yrs. mos. ds.

CONTRIBUTORY none
(Secondary) (Duration)..... yrs. mos. ds.

(Signed) D. O. Gillham M. D. 2-5, 1918 (Address) Jefferson City Mo.

*State the Disease Causing Death, or, in cases 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 City Cemetery J. C. Mo. DATE OF BURIAL 7 6, 1918
20 UNDERTAKER Oliver & Heinrichs ADDRESS Jeff. City 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*, *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 "*Ashtenia*," "*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 child-birth 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.)

1 PLACE OF DEATH

County LeveTownship
orVillage
orCity JeffersonREGISTRARS SHALL NOT RECEIVE
A FEE FOR CERTIFICATES UNTIL THEY
ARE COMPLETED AS PRESCRIBED BY
LAWMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 213 File No.Primary Registration District No. 3014 Registered No. 20(NO. 210 Jefferson St.: Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME John Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE
MARRIED widowed
WIDOWED
OR DIVORCED
(Write the word)6 DATE OF BIRTH Dec. 13 - 1833
Satisfactory Information Supplied
(Month) (Day)7 AGE 85 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)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 Feb. 6 1918 Audrey Jones
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 5 1918
(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.....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.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

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

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]

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4650

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.)