

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

1 PLACE OF DEATH
County Clatsop
Township Wyaconda Registration District No. 194 File No. 12536
or
Village _____ Primary Registration District No. 4117 Registered No. 6
or
City Wyaconda (NO. _____ St. _____ Ward _____)
2 FULL NAME Benjamin Franklin Ewing [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH September 11 1865
(Month) (Day) (Year)

7 AGE 52 yrs. 7 mos. 13 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE Clatsop Co. Mo
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER John Ewing

11 BIRTHPLACE OF FATHER Don't know
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER Mary Francis Cornelius

13 BIRTHPLACE OF MOTHER Don't know
(City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 24 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 8 1918 to Apr 24 1918 that I last saw him alive on Apr 24 1918 and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
82+
75 1/2 (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) _____ (Duration) yrs. mos. ds.
(Signed) S. E. Doss M. D. Apr 26 1918 (Address) Wyaconda

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Patrick
(Address) Wyaconda Mo

15 Filed April 26 1918 S. E. Doss
Registrar

*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 Bear Creek Cemetery DATE OF BURIAL Apr 26 1918

20 UNDERTAKER'S Guth & Bosker ADDRESS Wyaconda 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* (ne-

"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 "Asthemia," "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

1 PLACE OF DEATH

County *Clark*

Township

Registration District No. *194*

File No.

Village

Primary Registration District No. *4117*

Registered No. *6*

City

(NO. St. Ward)

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

2 FULL NAME

Benjamin Franklin Ewing

PERSONAL AND STATISTICAL PARTICULARS

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

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)

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 *Apr 26, 1918*
Registrar

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 h..... alive on..... 191
and that death occurred, on the date stated above..... m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) yrs. mos. ds. *64*

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds. *20*
(Signed) *S. E. Doss* M. D.
Apr 26, 1918 (Address) *Wyaconda*

*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..... 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 OF BURIAL
191

20 UNDERTAKER ADDRESS

Satisfactory Information Supplied.

Satisfactory Information Supplied.

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[Approved by U. S. Census and American Public Health
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"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," "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.)