

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

PLACE OF DEATH

County Macon
Township Lehenton
or
Village
or
City (NO. _____) St.: _____ Ward _____

Registration District No. 329 File No. 13891
Primary Registration District No. 3703 Registered No. 58

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

FULL NAME W J Ellis

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH 7 5 1866
(Month) (Day) (Year)
AGE 47 yrs. 9 mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Va
PARENTS
NAME OF FATHER Cont no
BIRTHPLACE OF FATHER (City or town, State or foreign country) Cont no
MAIDEN NAME OF MOTHER Cont no
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cont no

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Brown
(ADDRESS) Admore Me

Filed April 11, 1918 W J Harned
REGISTRAR

V MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4/7 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 7, 1918, to April 7, 1918, that I last saw him alive on April 7, 1918, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Heart Failure

928
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W J Harned M. D.
April 11, 1918 (Address) Admore

*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 _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Admore 33 Hill DATE OF BURIAL 4/15, 1918

UNDERTAKER Albert Skinner ADDRESS Macon

PLACE OF DEATH

County.....

Township.....

or Registration District No.

File No.

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	SINGLE	DATE OF BIRTH
	MARRIED	
COLOR OR RACE	WIDOWED	(Month), 191.....
	OR DIVORCED (If write the word)	(Day), 191.....
AGE	IF LESS than 1 day, hrs. or min.?	
OCCUPATION yrs. mos. ds.	

(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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH, 191.....
(Month), (Year)

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^r was as follows:

(Duration) yrs. mos. ds.

Contributory

{SECONDARY} (Duration) yrs. mos. ds.

(Signed), 191..... (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. 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

DATE OF BURIAL, 191.....

UNDERTAKER

ADDRESS

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

1 PLACE OF DEATH
Hagon
County *Hagon*
Township *Chanton*
or
Village
or
City

Registration District No. *529* File No.
Primary Registration District No. *5705* Registered No. *57*
St. (No.) Ward

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

2 FULL NAME *H. J. Ellis*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *4-7-18*
(Month) (Day) (Year)

6 DATE OF BIRTH (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.

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

The CAUSE OF DEATH was as follows:
Heart Failure
Chronic Valvular Heart Disease

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

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

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

(Signed) *H. J. Starned* M. D. April 11, 1918 (Address) *Ardmore*

10 NAME OF FATHER

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

12 MAIDEN NAME OF MOTHER

At place of death yrs. mos. ds. In the State yrs. mos. ds.

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

Where was disease contracted if not at place of death?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Former or usual residence.

(Informant)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

(Address)

20 UNDERTAKER ADDRESS

15 Filed April 11, 1918

Registrar *H. J. Starned*

Satisfactory Information Supplied.

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

13891
"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.)