

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

1 PLACE OF DEATH

County Ray
Township Calender
or
Village
or
City

Registration District No. 389 File No. 02815
Primary Registration District No. 8974 Registered No.
(NO. St. Ward)

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

2 FULL NAME James K Martin

PERSONAL AND STATISTICAL PARTICULARS	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>
5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>June 27 - 1843</u> (Month) (Day) (Year)	
7 AGE <u>70 - 6 mos. 14 ds.</u>	If LESS than 1 day... hrs. or... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Mines</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Mines</u>	
9 BIRTHPLACE (City or town, State or foreign country) <u>Lexington Mo</u>	
PARENTS	10 NAME OF FATHER <u>William Martin</u>
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>
	12 MAIDEN NAME OF MOTHER <u>_____</u>
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH 191..... (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: <u>124 B</u>	
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.....	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Martin
(Address) Orriek

15 Filed Jan 10, 1914 W. W. Burgess
Registrar

19 PLACE OF BURIAL OR REMOVAL
Smith Point
DATE OF BURIAL
Jan 12, 1914
20 UNDERTAKER
F. S. Rowland
ADDRESS
Orriek 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* (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 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.)

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

1. PLACE OF DEATH

County Ray Registration District No. 739 File No. _____
 Township Camden Primary Registration District No. 5974 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

James R Martin
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1919

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

17. I HEREBY CERTIFY That I attended deceased from 12/15 1918 to 1/10 1919
 that I last saw him alive on 1/10 1919, and that death occurred, on the date stated above, at 11/19 m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Sclerosis of Liver
 (duration) _____ yrs. _____ mos. _____ ds.

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

CONTRIBUTORY (SECONDARY) 113
 (duration) _____ yrs. _____ mos. _____ ds.

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

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) G.S. Purington M. D.
 , 19 (Address) Camden MO.

*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

20. UNDERTAKER ADDRESS

PARENTS

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 (Address) _____

15. FILED 4/4 1919 G.S. Purington REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

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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.