

W. F. Willcox

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

8508

1. PLACE OF DEATH

County *Andrew*

Registration District No. *96*

File No.

Township

Primary Registration District No. *3004*

Registered No. *No*

City *Mexico Mo.* (No. *Mexico Hospital*)

St. *3*

Ward

2. FULL NAME *John S. Jones*

(a) Residence No.

St.

Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *51* yrs. *—* mos. *—* ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *White*

5. ~~SINGLE~~ MARRIED, WIDOWED OR ~~OR~~ (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 17 1894*

7. AGE

YEARS *90*

MONTHS *7*

DAYS *25*

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer) *Stockman*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Womando, Mo.*

10. NAME OF FATHER *Mr. John Jones*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Miss Calloway*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

INFORMANT *Sam & John Jones*

(Address) *Kansas City Mo.*

15. FILED *Mar 3 1919* *Wm. H. Deering* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 27* 1919

17. I HEREBY CERTIFY, That I attended deceased from *Feb 27* 1919, to *Mar 2* 1919 that I last saw *him* alive on *Mar 1* 1919, and that death occurred, on the date stated above, at *H. A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobular Pneumonia

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (SECONDARY) *Myocarditis*

(duration) yrs. mos. ds.

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) *J. E. Miller*, M. D.

Mar 3, 1919 (Address) *Mexico, 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

Mexico, Mo. *Mar 3 1919*

20. UNDERTAKER

ADDRESS

McSheters Bros Mexico Mo

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

State of Missouri, County of Andrew, City of Mexico, Mo. Date of Death, Feb 27 1919. Age, 90 yrs, 7 mos, 25 ds. Sex, Male. Color or Race, White. Occupation, Retired. Cause of Death, Lobular Pneumonia. Contributory, Myocarditis. Burial, Mexico, Mo. Mar 3 1919. Undertaker, McSheters Bros, Mexico, Mo.

91432 29132 befinll bezi

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 *Ncne*.

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 "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

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.

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

1. PLACE OF DEATH

County Audrain Registration District No. 26 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 20
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. John S Jones St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) MAR 2 1919

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH WAS AS FOLLOWS

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

Lobar Pneumonia

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 _____

acute myocarditis
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

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) J. Miller, M.D.

7/19/19 _____ (Address) Mexico, Mo

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14. INFORMANT _____ (Address) _____

15. FILED July 7 1919 Malcolm Deane REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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