

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

19558

1. PLACE OF DEATH

County Jackson Registration District No. 398 ✓
 Township None Primary Registration District No. 3019
 City Independence (No. 1103 N. Walds) St. _____ Ward _____

2. FULL NAME

John Charles O'Neal
 (a) Residence, No. 1603 N. Walds St., _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hattie C. O'Neal

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 11 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Book keeper
 (b) General nature of industry, business, or establishment in which employed (or employer) Mo Portland Cement
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jeffersonville
 (STATE OR COUNTRY) Ind.

10. NAME OF FATHER John O'Neal

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Emma Tapp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ky

14. INFORMANT A. H. O'Neal
 (Address) Independence Mo

15. FILED 6-19-19 A. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1919

17. I HEREBY CERTIFY, That I attended deceased from _____
June 7, 1919, to June 17, 1919,
 that I last saw him alive on July 11, 1919, and that death occurred, on the date stated above at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

151 Encephalitis
186
 _____ (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Infected Wound of hand
 _____ (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF... ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓

(Signed) J. H. Beckman, M. D.

June 17, 1919 (Address) Independence 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 Woodlawn Cem. DATE OF BURIAL June 19 1919

20. UNDERTAKER W. L. Bowyer ADDRESS Independence Mo

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

MISSOURI STATE BOARD OF HEALTH

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 centered 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

B. OCCUPATION OF DECEASED

"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. *Meninges*; *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 carbonic 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

PARENTS

MISSOURI STATE BOARD OF HEALTH

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CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Jackson Registration District No. 398 File No. _____
 Township _____ Primary Registration District No. 3019 Registered No. 150
 City Independence (No. _____) St. _____ Ward _____

2. FULL NAME

John Charles O'neal
 (a) Residence No. _____ St. _____ Ward _____ (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

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

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

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

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

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 _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) _____

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 8/6, 1919 T. L. Look REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1919

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY Accidental wound of tongue (duration) _____ yrs. _____ mos. _____ ds.
 (SECONDARY) _____ (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. H. Johnson M. D.
Aug 3, 1919 (Address) Independence, Mo

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

20. UNDERTAKER ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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