

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

PLACE OF DEATH

County Shelby

Township Jackson

Village Lakeman

Registration District No. 829

File No. 21401

Primary Registration District No. 4502

Registered No. 2

(NO. _____ St. _____ Ward _____)

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

FULL NAME Thomas Benjamin James

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH November 2, 1832
(Month) (Day) (Year)

AGE 86 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. or min.?

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

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

NAME OF FATHER John H James

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

MAIDEN NAME OF MOTHER Don't know

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth James

(ADDRESS) Lakeman, Mo.

Filed 6/27/1919 A. T. White REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 25, 1919
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 17, 1919, to June 23, 1919, that I last saw him alive on June 22nd, 1919 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows: Nephritis
131

(Duration) Don't know yrs. mos. ds.

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

Signed J. W. Furnish M. D. June 26, 1919 (Address) Shelby, Missouri

*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 Prairie View Cemetery DATE OF BURIAL June 27, 1919

UNDERTAKER J. M. Thompson & Co. Hannibal ADDRESS _____

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

PLACE OF DEATH

County _____

Township _____ File No. _____

or _____ Registered No. _____

Village _____ Primary Registration District No. _____

or _____

City _____ (NO. _____) St. _____ Ward _____

(If death occurred hospital or institute give its NAME and of street and number?)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds.
 If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 19____, (Month) _____, 19____, (Day) _____, (Year) _____

I HEREBY CERTIFY, that I attended deceased fr. _____, 19____, to _____, 19____, that I last saw h alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The **CAUSE OF DEATH** was as follows:

_____ yrs. _____ mos. _____ ds.

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

Contributory
(SECONDARY) _____ (Address) _____

(Signed) _____ 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. 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 _____, 19____

UNDERTAKER _____

ADDRESS _____

Filed _____, 19____, _____

REGISTRAR

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

PLACE OF DEATH
 County Shelby Registration District No. 859 File No.
 Township Lakewood Primary Registration District No. 4502 Registered No. 2
 City Lakewood (No.) St. Ward)

FULL NAME Thomas Benjamin Jones
 (a) Residence No. St. (If nonresident, give city or town and State)
 (Usual place of abode)
 (b) 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

SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** M
 (writing the word)
 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 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 19 19
17. I HEREBY CERTIFY that I attended deceased from 19..... to 19.....
 that I last saw live on 19....., and that death occurred on the date stated above, at..... m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS: Nephritis Chronic
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 170
 (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)....., M. D.
 , 19 (Address)

*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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

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*, *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. *scpsis*, *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 gives 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.