

Permit - 365.

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

1 PLACE OF DEATH

County McDonald
Township Elle River Prairie Registration District No. 217 File No. 34646
or
Village Mad. Mo. Primary Registration District No. 5687 Registered No. 25
or
City (NO.) St. Ward

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

2 FULL NAME

Williams Owens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED married
WIDOWED OR DIVORCED
(Write the word)

6 DATE OF BIRTH February 8 1845
(Month) (Day) (Year)

7 AGE 75 yrs. 9 mos. 19 da. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Mad. Vernon, Ill.

PARENTS
10 NAME OF FATHER Elmer Owens
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland
12 MAIDEN NAME OF MOTHER Mahala Smith
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Family Record
(Address) by

15 Filed 11/27/20 H. V. Cynovick Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 19 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 17, 1920 to Nov 19, 1920, that I last saw him alive on Nov 14, 1920, and that death occurred, on the date stated above, at 11:00 p.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 6 da.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.
(Signed) B. S. Smith M. D.
Nov. 20, 1920 (Address) Southwest City, Mo.

*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. da. In the State yrs. mos. da.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oklahoma City, Okla. DATE OF BURIAL Nov 22, 1920
20 UNDERTAKER H. S. Dorman ADDRESS Highway 1, Ark.
Highway Springs

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.

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 Mc Donald Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. _____
 City Noel (No. _____) St. _____ Ward _____

2. FULL NAME

William Owens
 (a) Residence No. 123 Sulfur Stone Building just moved - it St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. 4 mos. 19 ds. How long in U.S., if of foreign birth? yrs. 74 mos. 9 ds. 19

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

7. AGE 74 YEARS 9 MONTHS 15 DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Blind
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mount Pleasant (STATE OR COUNTRY) I.L.

10. NAME OF FATHER Lemuel Owens

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

12. MAIDEN NAME OF MOTHER Mahala Smith

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

14. INFORMANT Dalbert Minity (Address) Copeland Hall Okla City

15. FILED Nov 21, 1920. REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 November 1920

17. I HEREBY CERTIFY, That I attended deceased from _____, 1920, to _____, 1920, and that I last saw _____ give on _____, 1920, and that death occurred on the date stated above, at _____, 19 12 Okla

THE CAUSE OF DEATH WAS AS FOLLOWS:
Old age
caused by Pneumonia
and Relapse

CONTRIBUTORY (SECONDARY) Pneumonia
Relapse
 (duration) _____ yrs. _____ mos. _____ ds. 9

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH, _____ Noel.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Dr. B.F. Smith M. D.
 , 19 (Address) Noel Southern City 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 Rose Hill " Okla DATE OF BURIAL 21 1920

20. UNDERTAKER John T. Dunn ADDRESS Sulfur Springs Ark

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

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Revised United States Standard Certificate of Death

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

34646

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"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite), *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of *Pneumonia* (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 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.