

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

3576

1. PLACE OF DEATH

County Delaware
Township Grant
City _____

Registration District No. 264
Primary Registration District No. 0-267

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

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 Bessie Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18th 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 | 1 | 1 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Mo.

10. NAME OF FATHER

do not know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

14.

INFORMANT Bessie Wilson
(Address) Maysville Mo.

15.

FILED Mar 21 1921
REGISTRAR D. C. Beckwith

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19th 1921

17. I HEREBY CERTIFY, That I attended deceased from _____
March 1919 to death 1921
that I last saw alive on Feb 14th 1921, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic degeneration of Spinal cord

CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED at his home
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) John M. Brown, M. D.
, 19 (address) Maysville

*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
Butter Cem - Grant Twp. 2/20 1921

20. UNDERTAKER ADDRESS
W. G. Coker Maysville Mo.

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

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

MAY 1918
CITY OF NEW YORK
DEPARTMENT OF HEALTH

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 *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., *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.

Wayssville Mo. April 31st 1921.
Mr L. A. Kitchy Fairport Mo

Dear sir

Do not know any contributory cause. He always worked hard. Had attacks of neuralgia, especially Sciatica. Why he developed the trouble in spinal cord, could we say either - a very slow growth - process on cord, producing degenerative changes with paralysis of lower limbs, was the cause, or degeneration (local) of unknown origin.

No autopsy was made, hence no positive confirmation of trouble can be positively stated. Refer this to the State Board.

Sincerely

J. W. Brown

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

1. PLACE OF DEATH
 County De Kalb Registration District No. 264 File No.
 Township Grant Primary Registration District No. 5-3-67 Registered No.
 City (No.) St. Ward)

2. FULL NAME John Francis Wilson
 (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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>m</u> <small>(write the word)</small>		
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)				
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....., 19..... REGISTRAR				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-19-21

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

CONTRIBUTORY (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)....., M. D.

....., 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

PHYSICIANS should state PERSON is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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

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