

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

11803

1. PLACE OF DEATH  
 County Boone Registration District No. 238 File No. 286  
 Township Edgar Primary Registration District No. 5326 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John Louis Miller  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29 - 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>40</u>	<u>9</u>	<u>9</u>	<u>13</u>	

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) Johnson Co. Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER William Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Susan Easter

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

14. INFORMANT Mrs. John Miller  
 (Address) Golden City, Mo. R.F.D.

15. FILED 5-12-1921 of J. D. Wren  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 - 1921

17. I HEREBY CERTIFY, That I attended deceased from April 1 - 1920 to May 12 - 1921 that I last saw him alive on May 12 - 1921, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Osteo-Sarcoma of Inferior Maxilla 4508

Probably about eighteen months  
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 1920

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? microscopical

(Signed) J. M. Brooks, M. D.

May 13, 1921 (Address) Golden 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 DATE OF BURIAL

Moorehead Cem. Boone Co. Mo. 5-12-1921

20. UNDERTAKER

E. B. Phillips Golden City, Mo.

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*, *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.

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

Do not use this space.

11397-a  
19076-a

**1. PLACE OF DEATH**

County Bartonsville Registration District No. 1  
Township Newport Primary Registration District No. 3057  
City (No.         ) St.          Ward         

File No.           
Registered No.         

**2. FULL NAME**

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29-1880

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
40 | 9 | 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.         

10. Date deceased last worked at this occupation (month and year)          11. Total time (years) spent in this occupation         

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co. Mo.

13. NAME William Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME Susan Easter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT Mrs. J. F. Miller

18. BURIAL, CREMATION, OR REMOVAL          DATE May 13-1921

19. UNDERTAKER E. A. Phillips

(ADDRESS)         

20. FILED          19          Registrar         

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12 1921

22. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to May 12 1921

I last saw him alive on May 10 1921 Death is said to have occurred on the date stated above, at 11:00 P. m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of lower jaw

450 4510

Other contributory causes of importance:         

Name of operation          Date of         

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?          Date of injury         , 19         

Where did injury occur?          (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.         

Manner of injury         

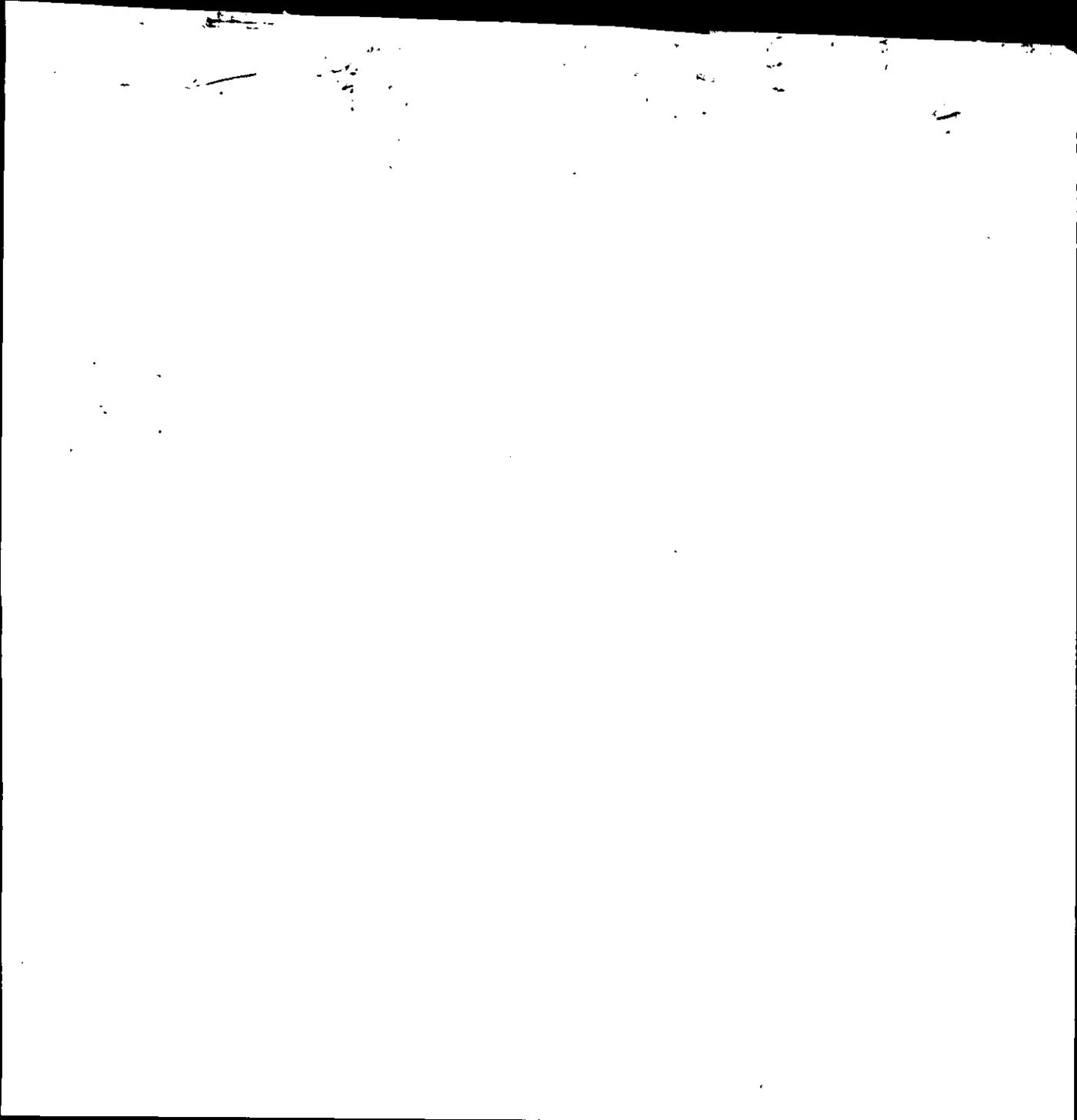
Nature of injury         

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify         

(Signed) J. B. Bridges, M. D.

(Address) Sunder City Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Barton  
Township Newport  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 1008  
Primary Registration District No. 1057

File No. \_\_\_\_\_  
Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John Louis Miller

(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 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
40 4 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co. Mo.

13. NAME William Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME Susan E. Miller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mrs. J. C. Smith, D.

18. BURIAL, CREMATION, OR REMOVAL St. Charles, Mo. DATE May 13, 1921

19. UNDERTAKER (ADDRESS) E. A. Phillips, Golden City, Mo.

20. FILED Dec 23, 1931 J. W. Wise Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12, 1921

22. I HEREBY CERTIFY, that I attended deceased from July 10, 1920 to May 12, 1921, 1921. I last saw him live on May 10, 1921. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Carcinomas of Lower Jaw

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) J. M. Brooks, M. D.  
(Address) Golden City, Mo.

SUPPLEMENTARY

