

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

21284

1. PLACE OF DEATH

County Remick Registration District No. 1099 File No. _____
 Township Little River Primary Registration District No. 5868 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

James Moy
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 13 yrs. 11 mos. 10 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>		
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.
<u>1</u>	<u>3</u>	<u>11</u>	<u>15</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				
9. BIRTHPLACE (CITY OR TOWN) _____ <u>Jackson</u> (STATE OR COUNTRY) _____ <u>Missouri</u>				
10. NAME OF FATHER _____ <u>Alfred Moy</u>				
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ <u>Don't know</u> (STATE OR COUNTRY) _____				
12. MAIDEN NAME OF MOTHER _____ <u>Collie Freeman</u>				
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ <u>Jackson</u> (STATE OR COUNTRY) _____ <u>Missouri</u>				

MEDICAL CERTIFICATE OF DEATH

1. 1
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 19 21
 17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Aug 19, 1921 that I last saw him alive on Aug 19, 1921, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental gunshot wound of abdomen and chest
1921 (duration) 0 yrs. 0 mos. 9 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) J. L. McAlister, M. D.
 (Address) Wardell 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.)

14. INFORMANT M. M. Moore
 (Address) Wardell Mo.
 15. FILED Nov 22, 21 J. L. McAlister
 sub. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wardell Mo DATE OF BURIAL 8-21 19 21
 20. UNDERTAKER M. M. Moore ADDRESS Wardell 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.

DEPARTMENT RECORD

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 neoplasma); *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**

21284

1. PLACE OF DEATH

County Scott Registration District No. 2090 File No. _____
Township TITLE RIVER Primary Registration District No. 239 Registered No. 6
City _____ (No. _____) St. _____ (Ward)

2. FULL NAME James M. Hollands

(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 13 yrs. 11 mos. 15 da. How long in U.S., if of foreign birth? yrs. ____ mos. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 9. 1908

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>13</u>		<u>11</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) In school
(c) Name of employer Walter Hollands

9. BIRTHPLACE (CITY OR TOWN) Jackson Tenn
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Walter Hollands</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Jackson Tenn</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Callie Freeman</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Jackson Tenn</u> (STATE OR COUNTRY)

14. INFORMANT N. M. Moore
(Address) Wardell Mo.

15. FILED 9-1 1921 J. B. Stemann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1921

17. I HEREBY CERTIFY That I attended deceased from Aug 18 1921 to Aug 20 1921 that I last saw h. 1m alive on Aug 19 1921, and that death occurred, on the date stated above, at 8:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental gun-shot wound in abdomen and chest.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. ____ mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ yrs. ____ mos. ____ da.

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? No
(Signed) J. L. M. Alister M. D.

8-20, 1921 (Address) Wardell 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 Near Wardell Mo. DATE OF BURIAL 8/21/21
19

20. UNDERTAKER N. M. Moore ADDRESS Wardell Mo.

WRITE PLAINLY WITH UNFAADING INK—THIS IS A PERMANENT RECORD

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, 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 child-birth 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*, *collulitis*, *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.

Wardell Mo.

Nov. 22/21

Board of Health.

Jefferson City Mo.

Gentlemen- Am sending death certificate of James Moy as per inclosure. The death was reported under the name of James M. Hollands at the time it occurred. This was due to thinking that he was an own son of Walter Hollands , when he was a step son.

Please advise me if I can do anything farther.

Resp

J. L. McAlister M.D.
J. L. McAlister M.D.

2128B

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

1. PLACE OF DEATH

County... Pennicott
Township... Little River
City... (No.)

Registration District No. 1099
Primary Registration District No. 5868

File No.
Registered No. 6
St. Ward)

2. FULL NAME

James May Hollands.
(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 <u>m</u>	4. COLOR OR RACE <u>n</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>2</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 5th 1907</u>		
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: 9-1-21 J. B. Steiner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 - 1921
17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (duration) yrs. mos. da.
that I last saw live on 19....., and that death occurred on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: (duration) yrs. mos. da.

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

19

20. UNDERTAKER

ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

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V. S. No. 2.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

21284

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.