

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

28471^a

1. PLACE OF DEATH

County Henry
Township Burgard
City Henry (No.)

Registration District No. 95 3
Primary Registration District No. 5485 B

File No. 2
Registered No. 182
St. Ward

2. FULL NAME

James Jacob Robinson

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

Length of residence in city or town where death occurred 45 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 15 - 1845

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>77</u>	<u> </u>	<u>9</u>	<u>15</u>	<u> </u>

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER James Robinson

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

12. MAIDEN NAME OF MOTHER Johanson

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

14. INFORMANT Nellie Robinson
(Address) Wash. Mo

15. FILED 11-5-22 L. R. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1922

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 to Dec 30 1922 that I last saw him alive on Dec 30 1922 and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial
12.43
11.1 (duration) 15 yrs. mos. ds.
CONTRIBUTORY Senile dementia
(SECONDARY) (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. B. Smith M. D.
, 19 (Address) Wash 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 Nov 1 1922

Heard Cemetery

20. UNDERTAKER R. B. Arnold ADDRESS Creighton Mo

N. No. of information should be obtained EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. 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 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.

1 PLACE OF DEATH

County

Township

Village

City

Newry
Boquet

(No.

St.;

Ward)

Registered No.

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

2 FULL NAME

James Jacob Robinson

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of

353
5485 B.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX-

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(If state the word)

M

W

W

6 DATE OF BIRTH

Jan 15, 1895

7 AGE

77 yrs. 9 mos. 15 ds.

If LESS than
1 day, hrs.
or min. ?

8 OCCUPATION

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

Farmer

(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Ohio

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 3/24, 1923 Ed. C. Reel
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h... alive on , 191...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

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

(Signed) ... M. D.

, 191... (Address)

* 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. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted,
if not at place of death ?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY

are fully or

B. - Every

Every item of information 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. See instructions on back of certificate.

A PERMANENT RECORD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

28471-A

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