

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

21224

1. PLACE OF DEATH

County Boonville
Township Boonville
City Boonville (No. _____) (Sl. _____ Ward)

Registration District No. 701
Primary Registration District No. 74422

File No. _____
Registered No. 33

2. FULL NAME

Johnson Farmer

(a) Residence No. _____ Sl. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs 3 mos 29 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 Ruby Farmer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1886-3-28

7. AGE 38 YEARS MONTHS 8 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED Laborer Day
(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) Boonville Mo
(STATE OR COUNTRY)

10. NAME OF FATHER John Farmer

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

12. MAIDEN NAME OF MOTHER Corra Gibley

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

14. INFORMANT (Address) John H. Farmer Boonville Mo

15. FILED July 27 1924 REGISTRAR A. J. White

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1924

17. I HEREBY CERTIFY That I attended deceased from July 27 1924 to July 27 1924 that I last saw him alive on July 27 1924, and that death occurred, on the date stated above, at 4 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Gun shot wound Homicidal
1923
1924 (duration) 1 yrs. 4 mos. 1 ds.

CONTRIBUTORY (SECONDARY) 1917
(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? (Signed) John W. Cox M. D.
July 27 1924 (Address) Boonville 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 Boonville Mo DATE OF BURIAL 7-29 1924

20. UNDERTAKER W. S. White ADDRESS Boonville Mo

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
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CERTIFICATE OF DEATH

SUPPLEMENTAL

1. PLACE OF DEATH

County Boon Registration District No. 2 Sub No. 2
 Township _____ Primary Registration District No. 14427 Registered No. 33
 City Boon (Name) _____ St. _____ Ward _____

2. FULL NAME Elzot J. Farmer

(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
(write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
38 2 2

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Boon Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER John Farmer

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

12. MAIDEN NAME OF MOTHER Coral Easley

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

14. INFORMANT John J. Farmer
 (Address) Boon Mo

15. FILED July 29 1924 J. F. Robit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1924

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 27, 1924 that I last saw him alive on July 27, 1924 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gunshot wound
(homicide)

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

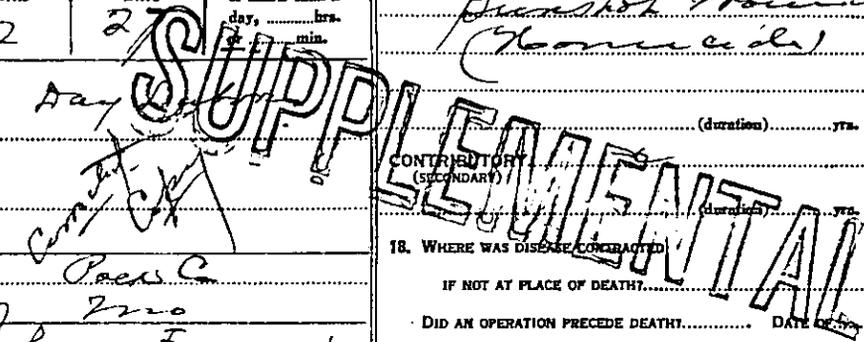
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) John M. Ray, M. D.
July 29 1924 (Address) Boon Mo

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL Boon Cemetery DATE OF BURIAL July 29 1924
 ADDRESS Boon Mo

20. UNDERTAKER W. S. White



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