

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

Do not use this space.

10406

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 358
 City Springfield Mo. Springfield Baptist Hospitals. (Ward)

2. FULL NAME

John H. Firestone
Bloodland Mo. St. _____ Ward _____
 (a) Residence. No. _____ (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Bell Firestone
don't know

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
55 3 17

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) Penn.

10. NAME OF FATHER O. H. Firestone

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

12. MAIDEN NAME OF MOTHER Thursday Craft

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

14. INFORMANT O. H. Firestone

(Address) Bloodland Mo.

15. May 31 19 25 Edwin F. James
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 17 19 25

17. I HEREBY CERTIFY That I attended deceased from 4 - 15 19 25 to 4 - 17 19 25
 that I last saw h. im alive on 4 - 17 19 25, and that death occurred, on the date stated above, at 3:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis Con'tl.

(duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY Rup't Gangrenous Appendix
 (SECONDARY)

(duration) _____ yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED Bloodland Mo.
 IS NOT A PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4/15 25

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Wilber Smith, M. D.

4/17, 19 25 (Address) Springfield No.

*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 Bloodland Mo. DATE OF BURIAL 4 - 18 19 25

20. UNDERTAKER W. L. Starne ADDRESS Walnut & Market

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.

WHILE PLAINLY, WITH OBTAINING INFORMATION THIS IS A FURNISHED 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 neoplasm); *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.

STATE OF MISSOURI)
) SS
COUNTY OF GREENE)

I, the undersigned, do hereby certify that the attached is a true and exact copy of the original Death Certificate of John H. Firestone, as filed in the office of the Registrar in Springfield, Missouri.

Katheryn Wheeler

Subscribed and sworn to before me, a Notary Public within and for the County of Greene, State of Missouri, this 12th day of June, 1925. My Commission expires October 1, 1928.

Willene M. Ramey

11406

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

1. PLACE OF DEATH.

County Green Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 358
 City Springfield, Mo. Springfield Baptist Hospital (Ward) _____

2. FULL NAME

(a) Residence. 250 Bloodland, Mo. 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 Anna Bell Firestone

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23, 1870

7. AGE YEARS MONTHS DAYS if LESS than 1 day, _____ hrs. or _____ min.
55 2 24

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) Dewey
 (STATE OR COUNTRY) Labette Co. Mo.

10. NAME OF FATHER B. N. Firestone

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

12. MAIDEN NAME OF MOTHER Thursday Craft

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

14. INFORMANT John A. Firestone
 (Address) Bloodland, Mo.

15. FILED 5/11, 1925 Edw. J. [unclear] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 17 1925

17. I HEREBY CERTIFY, That I attended deceased from 4-15-25 to 4-17-25, 1925
 that I last saw him alive on 4-17-25, 1925; and that death occurred, on the date stated above; at 3:30 am.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Peritonitis Genill

(duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) Rup's Gangrenous appendix

(duration) _____ yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Bloodland, Mo.

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4-15-25

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) Willie Smith, M. D.

1925 (Address) Springfield, Mo

*State the DISEASE CAUSING DEATH, 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

Big Piney Cemetery 4-18-1925
Big Piney, Mo.

20. UNDERTAKER H. L. Stame Walnut & Market

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.
 N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact status of DEATH in plain terms, so that it may be properly classified. Exact status of DEATH in plain terms, so that it may be properly classified. Exact status of DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY

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(Approved by U. S. Census and American Public Health Association.)

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