

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

Do not use this space.

14350

1. PLACE OF DEATH

County Buchanan

Registration District No. 35

File No.

Township.....
City St. Joseph,

Primary Registration District No. 1000
Missouri Methodist Hospital

Registered No. 562

(No.)

St.

Ward)

2. FULL NAME Ezekiel Andrew Downing,

(a) Residence. No. St.

Ward. 1 Mile West, DeKalb, Mo.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 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

Mary J. Downing,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 3rd. 1858.

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

66

8

9

9. 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) Platte County,
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Ezekiel Downing

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Kentucky,

12. MAIDEN NAME OF MOTHER Rebecca Stephens

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Kentucky,

14.

INFORMANT Jesse Downing
(Address) DeKalb, Missouri

15.

MAY 13 1925 Ezra Harrison
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY That I attended deceased from May 12, 1925, to May 12, 1925, that I last saw him alive on May 12, 1925, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Septicemia following
lung abscess

CONTRIBUTORY (SECONDARY)

lung abscess

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: De Kalb Mo

DID AN OPERATION PRECEDE DEATH: yes DATE OF May 1-25

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation & x ray

(Signed) W. H. Walker, M. D.

5/13, 1925 (Address) 501 N. St. Joseph 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

DeKalb cemetery

DATE OF BURIAL

May 13, 1925

20. UNDERTAKER

Heaton-Bellale Und. Co.

ADDRESS

319 S. 10th.

by J. H. Karlo

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT 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, peritoncum, 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, orysepelas, 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**

1. PLACE OF DEATH.

County Buchanan Registration District No. _____ File No. _____
 Town _____ Primary Registration District No. _____ Registered No. 562
 City St Joseph (No. Missouri Methodist Hospital St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. 1 mi. west - DeKalb, Mo.
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19__

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

17. I HEREBY CERTIFY That I attended deceased from _____, 19__ to _____, 19__ that I last saw him _____ alive on _____, 19__, and that death occurred, on the date stated above, at _____ m.

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Septicemia, following Lung Abscess.
Following lobar pneumonia (duration) yrs. mos. ds.

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 _____

CONTRIBUTORY (SECONDARY) Lung Abscess (duration) yrs. mos. ds. 10 ds.

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

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

10. NAME OF FATHER _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) _____, M. D. _____, 19__ (Address) _____

14. INFORMANT (Address) _____

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15. FILED 7/3/15 Eva Harrison REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19__

20. UNDERTAKER _____ ADDRESS _____

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. REGISTRARS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

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