

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

4647

PLACE OF DEATH
County Oregon (Was Troobinghome)

Township Wagon Registration District No. 389 File No. H
or Wagon
Village _____ Primary Registration District No. 5543 Registered No. _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

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

2 FULL NAME Jimm. Gee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 MARRIED married
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH May 1 1858
(Month) (Day) (Year)

7 AGE 57 yrs. 10 mos. 8 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 (City or town, State or foreign country) Tenn

PARENTS
10 NAME OF FATHER W. P. Gee
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Dout. Know
12 MAIDEN NAME OF MOTHER Jennie Garrison
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dout. Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Gee
(Address) Mountain Grove

15 Filed Feb 16 1927
W. A. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 8 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 2 1927 to Feb 8 1927 that I last saw him alive on Feb 8 1927 and that death occurred, on the date stated above, at 9:20 AM

The CAUSE OF DEATH* was as follows:
Hemorrhage of Lungs
1148
(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) _____
(Duration).....yrs.....mos.....ds.
(Signed) Dr. J. M. Davis M. D.
Feb 8 1927 (Address) Thomasville, Mo

*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 Bus Wayside DATE OF BURIAL 2/16 1927

20 UNDERTAKER M. J. Chase ADDRESS Thayer Mo

WRITE PLAINLY IN 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Shawnee Registration District No. 389 File No.
 Township North Primary Registration District No. 554-3 Registered No. 4
 City Myrtle (No.) St. Ward)

2. FULL NAME Jim Lee
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 9 7

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)

PARENTS
 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 2/27 1927 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 8 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Removal of stage of lungs
Extra Pulver yrs. mos. da. 4

CONTRIBUTORY (SECONDARY) 10702

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

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

20. UNDERTAKER ADDRESS
no undertaker

ENT RECORD

THIS IS A

UNFADING

WHIT

N. B.—Every item of information should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it is clearly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

H. A. THOMPSON, M. D.

PHYSICIAN AND SURGEON.

r. Stewart. Sec. State. Board ^{LANTON, MO.} Health. 1/17/28
Jefferson. City. Mo.

Dear. Sir am unable to give any futher infomation in regard to
the cause ed Death this man was a Laborer on state Road and developed
a Pulmonary Hemorage and Died Shortly after there was no Post mortum
but was supposed that there was a rupture of Pulmonary Artery. from
from extra exertion in performing the work
Dr Davis of Thomersville he cared for his man
and he might furnish something futher in regard to the cause
i Notice you hav the Name Jim. Lee it should be Jim. Gee
Very. Truly.

H. A. Thompson

cated by check marks, lacking from the death certificate:

Name: Jim Lee Lee

Who died at: Howell Co. on Feb. 8, 1927,

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) 202

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Hemorrhage of Lungs
Injury from Extra Labor.

Contributory: _____

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? no What test confirmed diagnosis? _____

Name of physician: W. H. Thompson

Address of physician: Linton Mo