

21449

County Premise moTownship CooterRegistration District No. 656

File No. \_\_\_\_\_

Inc. Town or City \_\_\_\_\_

Primary Registration District No. 5849

Registered No. \_\_\_\_\_

(No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

2 FULL NAME

James Miller

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

(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

## MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR or RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Married16 DATE OF DEATH 6-4-1928  
Month Day Year6a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Husband17 I HEREBY CERTIFY, That I attended deceased from 5-28-1928 to 6-4-1928  
that I last saw him alive on 6-4-19286 DATE OF BIRTH \_\_\_\_\_ 1879  
Month Day Yearand that death occurred, on the date stated above, at 7:30 m.  
The CAUSE OF DEATH\* was as follows:7 AGE 49 Years Months Days If LESS than 1 day, hrs. or mins.Pneumonia8 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 \_\_\_\_\_10.9M (duration) yrs. mos. 9 da.  
CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) yrs. mos. da.9 BIRTHPLACE (city or town) Tenn  
(State or country)18 Where was disease contracted  
If not at place of death? \_\_\_\_\_10 NAME OF FATHER John Miller

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) Tenn  
(State or country)

What operation performed? \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Annie Brown

Was there an autopsy? \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) Tenn  
(State or country)

What test confirmed diagnosis? \_\_\_\_\_

14 Informant Ernest Smith  
(Address) Hemondale mo.(Signed) R. M. Williams M. D.  
6-8-1928 (Address) Blytheville15 Filed 6-4-1928 James A Jones  
Registrar

\* 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.)

Burial or Translt/ Permit issued by James A Jones

19. PLACE OF BURIAL, CREMATION, or REMOVAL DATE OF BURIAL

20 UNDERTAKER Charles J. Galt ADDRESS BlythevilleDate of issue 6-4-1928

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

“Coma,” “Convulsions,” “Diphtheria,” “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 septi-  
 cemia,” “PUERPERAL peritonitis,” etc. State cause  
 for which surgical operation was undertaken. For  
 VIOLENT DEATHS state MEANS OF INJURY and qualify  
 as ACCIDENTAL, SUICIDAL, or HOMOCIDAL, or as prob-  
 ably such, if impossible to determine definitely. Ex-  
 amples: *Accidental drowning; Struck by railway  
 train—accident; Revolver wound of head—homi-  
 cide; Poisoned by carbonic 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 Medi-  
 cal Association.)

Note.—Certificates may be returned for additional in-  
 formation which give any of the following diseases,  
 without explanation, as the sole cause of death: Abor-  
 tion, cellulitis, childbirth, convulsions, hemorrhage, gan-  
 grene, gastritis, meningitis, miscarriage, necrosis, peri-  
 tonitis, phlebitis, pyemia, septicemia, tetanus.

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, ir-  
 respective of age. For many occupations a single  
 word or term on the first line will be sufficient, e. g.,  
*Farmer or Planter, Physician, Composer, Archi-  
 tect, Locomotive engineer, Civil engineer, Stationary  
 fireman, etc.* But in many cases, especially in in-  
 dustrial 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 *House-  
 keepers* 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 occupa-  
 tion at beginning of illness. If retired from busi-  
 ness, that fact may be indicated thus: *Farmer (re-  
 tired, 6 yrs.).* For persons who have no occupation  
 whatever, write *None.*

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
 BY PHYSICIAN.

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 re-  
 port “Typhoid pneumonia”); *Lobar pneumonia;*  
*Bronchopneumonia* (“Pneumonia,” unqualified, is  
 indefinite); *Tuberculosis of lungs, meninges, peri-  
 toneum, 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* (dis-  
 ease causing death), 29 ds.; *Bronchopneumonia*  
 (secondary), 10 ds. Never report mere symptoms or  
 terminal conditions, such as “Asthenia,” “Anemia”  
 (merely symptomatic), “Atrophy,” “Collapse,”

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Leopold  
Township Walter  
City (No. ....) St. .... Ward)

Registration District No. 63-6  
Primary Registration District No. 3873

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

James Miller

(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 M 4. COLOR OR RACE B 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) 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
49 5 4

**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)

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 6-19-28 James Rogers REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1928

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.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia  
Broncho Pneumia

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

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.

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

St. Ann's Halland Ave 6-9 1928

20. UNDERTAKER ADDRESS

Helix Club

SUPPLEMENTARY

1000

K. 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. REGISTRARS SHALL NOT RECEIVE A FILE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-21449