

251 1929

MISSISSIPPI STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Pemiscou
Township Centre Registration District No. 656 File No. _____
Inc. Town of Costantino, Mo. Primary Registration District No. 58019 Registered No. _____
City _____ (No. _____) St.; _____ Ward _____

2 FULL NAME Arch Capell Jr
(a) Residence. No. Costantino, Mo. 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.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR or RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH Dec 15 1922
Month Day Year

7 AGE Years 6 Months 0 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer) _____
(c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 27 1928
Month Day Year

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1928 to Dec 27 1928, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH 'was as follows:
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.)
Chump
1057A
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) _____
(State or country) Tennessee

10 NAME OF FATHER A. B. Capell

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Tennessee

12 MAIDEN NAME OF MOTHER Hellie Arbata

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Tennessee

14 Informant J. A. Allen
(Address) 7 Number Nine Ark

15 Filed 1-20, 1929 James O James
Registrar

18 Where was disease contracted _____
if not at place of death? _____
Did an operation precede death? _____ Date of _____
What operation performed? _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
Signed) W. M. C. C. C. M. D.
Dec 21-1928 (Address) _____

19. PLACE OF BURIAL, CREMATION, or REMOVAL Finley, Tennessee DATE OF BURIAL Dec. 28 1928

20 UNDERTAKER Wytheville Undertaking Co., Inc. ADDRESS Blytheville

Burial or Transit Permit issued by _____ Date of issue _____
Arch

MARGIN RESERVED FOR BINDING

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.

V. S. No. 4

41989

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," "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 HOMOCIDAL, 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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus*.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Mr. Call