98 1930

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

Do not use this space.

5568

File No.

Registered No.

1. PLACE OF DEATH

County: Lewis

Township: Dickerson

City (No. St. Ward)

Registration District No. 482

Primary Registration District No. 5646

2. FULL NAME James Allen Moore

(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 62 yrs. 6 mos. 6 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

6. DATE OF BIRTH (month, day and year): 1867 - July 31

7. AGE: Years 62, Months 6, Days 6. If LESS than 1 day, ...hrs. or ...min.

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): Lewis Co

(State or country)

PARENTS

10. NAME OF FATHER: David Moore

11. BIRTHPLACE OF FATHER (city or town)

(State or country)

12. MAIDEN NAME OF MOTHER: Easley

13. BIRTHPLACE OF MOTHER (city or town)

(State or country)

14. Informant: Mrs Kate Moore

(Address): Ewing, Mo.

15. Filed Febr 12 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year): Feb 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1930, to Feb 7 1930 that I last saw him alive on Feb 7, 1930, and that death occurred, on the date stated above, at 6:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Thrombosis

948

97

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY): Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo O Rouner, M.D.

, 19 (Address) Ewing 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: Gilroy Cemetery

DATE OF BURIAL: Feb 9 1930

20. UNDERTAKER: Thos Ball & Co.

ADDRESS: Ewing Mo

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; Bron pneumonia* ("Pneumonia," unqualified, is indefin *Tuberculosis of lungs, meninges, peritoneum,* *Carcinoma, Sarcoma,* etc., of————(name gin; "Cancer" is less definite; avoid use of "Tum for malignant neoplasm); *Measles, Whooping co Chronic valvular heart disease; Chronic interst nephritis,* etc. The contributory (secondary or tercurrent) affection need not be stated unless portant. Example: *Measles* (disease causing dea 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* N report mere symptoms or terminal conditions, s as "Asthenia," "Anemia" (merely symptoma "Atrophy," "Collapse," "Coma," "Convulsio "Debility" ("Congenital," "Senile," etc.), "Drop "Exhaustion," "Heart failure," "Hemorrhage," anition," "Marasmus," "Old age," "Shock," "U mia," "Weakness," etc., when a definite disease be ascertained as the cause. Always qualify diseases resulting from childbirth or miscarriage "PUERPERAL *septicemia,*" "PUERPERAL *peritonit* etc. State cause for which surgical operation undertaken. For VIOLENT DEATHS state MEANS INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to termine definitely. Examples: *Accidental dro ing; struck by railway train—accident; Revolver wou of head—homicide; Poisoned by carbolic acid—pr ably suicide.* The nature of the injury, as fract of skull, and consequences (e. g., *sepsis, tetanu* may be stated under the head of "Contributory (Recommendations on statement of cause of dea approved by Committee on Nomenclature of t American Medical Association.)

NOTE.—Individual offices may add to above list of unde able terms and refuse to accept certificates containing the Thus the form in use in New York City states: "Certifica will be returned for additional information which give any the following diseases, without explanation, as the sole cau 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.

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: Lewis — Registration District No.: 482 — File No.:
Township: Dickerson — Primary Registration District No.: 5-646 — Registered No.:
City: (No.: , St. Ward)

2. FULL NAME: James Allen Moore

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

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

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

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

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) Not given
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Not Known

14. INFORMANT
(Address)

15. FILED 2/12 1930 Chas Ferrall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

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

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT REQUIRE A FEE FOR SUPPLYING BLANKS OR FOR RECEIVING AND RECORDING THEREON COMPLETE AS PRESCRIBED BY LAW

5-5568