

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

PLACE OF DEATH  
County Henry  
Township Lebo Registration District No. 249 File No. 28088  
or  
Village \_\_\_\_\_ Primary Registration District No. H207 Registered No. 13  
or  
City Calhoun (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
FULL NAME John Art Greeson (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If widowed, give date)
DATE OF BIRTH <u>May 19, 1842</u> (Month) (Day) (Year)		
AGE <u>69</u> yrs. <u>1</u> mos. <u>28</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>0-02</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Lebensborough Mo.</u>		
PARENTS	NAME OF FATHER <u>Leonax Greeson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Lebensborough Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Envelope Clark</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lebensborough Mo.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. H. Greeson</u> (ADDRESS) <u>Calhoun, Mo.</u>		
Filed <u>8-20-1911</u> <u>J. E. Neely</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 18, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan, 1900, to July, 1911, that I last saw him alive on March, 1910, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH was as follows:  
Hypertrophy of the Mitral valve.  
9311  
7542

Duration) 2 yrs. 6 mos. ds.  
Contributory Cardiac dropsy  
(SECONDARY) Duration) 3 yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) J. H. Greeson M. D.  
July, 1911 (Address) Lincoln, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL <u>Calhoun, Mo.</u>	DATE OF BURIAL <u>7-10</u> , 19 <u>11</u>
UNDERTAKER <u>W. C. Butler</u>	ADDRESS <u>Calhoun, Mo.</u>

REPRODUCED FROM ORIGINAL RECORDS OF THE MISSOURI STATE BOARD OF HEALTH. 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*, *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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, 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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CERTIFICATE OF DEATH

PLACE OF DEATH

County Henry  
Township Felsa  
or  
Village \_\_\_\_\_  
or  
City Cathoun Mo. (NO. \_\_\_\_\_)

Registration District No. 349  
556  
File No. 28588  
Primary Registration District No. 5487 Registered No. 14  
4207 St.: \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Art Gresson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married  
WIDOWED  
OR DIVORCED  
(If write the word)

DATE OF BIRTH May 19 1842  
(Month) (Day) (Year)

AGE 69 yrs. 1 mos. 28 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Greensboro NC

NAME OF FATHER Leonard Gresson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Greensboro NC

MAIDEN NAME OF MOTHER Pauline Clapp

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Greensboro NC

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Gresson

(ADDRESS) Cathoun Mo.

Filed 7/18 1911 J. T. Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 18 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 1900, to July 1911, that I last saw him alive on March 1910, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH\* was as follows:  
Hypertrophy of mitral valve

(Duration) 2 yrs. 6 mos. \_\_\_\_\_ ds.

Contributory cardiac dropsy  
(SECONDARY) (Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. A. Gresson M. D.  
July 1911 (Address) Cathoun Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Cathoun Mo. DATE OF BURIAL 7/18 1911

UNDERTAKER W. C. Butler ADDRESS Cathoun Mo.

RECORDED IN BIRTH RECORDS, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

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