

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

1059

PLACE OF DEATH
County Henry
Township Reesville
or
Village _____
or
City Coal (NO. _____ St. _____ Ward _____)

Registration District No. 1114
Primary Registration District No. 5504B

File No. T-3
Registered No. 3

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

FULL NAME J. A. Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OF RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH 2/3 1849
(Month) (Day) (Year)

AGE 67 yrs. 11 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Ill

PARENTS
NAME OF FATHER Milton Davis
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Lucy McMurphy
BIRTHPLACE OF MOTHER (City or town, State or foreign country) New York

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. C. Peeler
(ADDRESS) Clinton Mo

Filed 1/19 1917 Ed. C. Peeler
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1/19 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1/12, 1917, to 1/19, 1917, that I last saw him alive on 1/12/17, 1917, and that death occurred, on the date stated above, at 9A m.
The CAUSE OF DEATH* was as follows:

Bronchitis
10 hrs
(Duration) ____ yrs. ____ mos. 14 ds.

Contributory Starvation
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Ed. C. Peeler M. D.
1/19, 1917 (Address) Clinton 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 Good Hope Co DATE OF BURIAL 1/20 1917

UNDERTAKER Swiss & Hunt ADDRESS Clinton Mo

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. 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*, *peritonaeum*, 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

BUREAU OF VITAL STATISTICS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Newport
 Township Leesville
 or
 Village
 or
 City

Registration District No. 1114 File No.
 Primary Registration District No. 5501-B Registered No. 3
 (NO. St. Ward)

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

2 FULL NAME

John A Davis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH 11/19 1917
 (Month) (Day) (Year)

6 DATE OF BIRTH (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1917 to 1917, that I last saw him alive on 1917 and that death occurred, on the date stated above, at 1917 m.

7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* as follows:

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

Pneumonia Bronchitis
 (Duration) yrs. mos. ds. 14

9 BIRTHPLACE (City or town, State or foreign country)

CONTRIBUTORY (Secondary) Starvation
 (Duration) yrs. mos. ds. 5

10 NAME OF FATHER

(Signed) Geo. E. Beeson M. D.
11/19 1917 (Address) etc to me

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

12 MAIDEN NAME OF MOTHER

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

*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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant)

Where was disease contracted if not at place of death?

(Address)

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

15 Filed 11/19 1917 Geo. E. Beeson Registrar

Original file, date

1917

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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Tuberculosis of lungs, meninges, peritonaeum, 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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *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.)

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