

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

PLACE OF DEATH

County Knox
Township Leahey
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1056 File No. 14 23334
Primary Registration District No. 3394 Registered No. 14

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

FULL NAME John Lewis Carder

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH March 3, 1843
(Month) (Day) (Year)

AGE 60 yrs. 4 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER French Carder
BIRTHPLACE OF FATHER Virginia
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mandy Goodman
BIRTHPLACE OF MOTHER Virginia
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Bertson
(ADDRESS) Knox City Mo

Filed July 12, 1913 L. E. Hoffmann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 31, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 20, 1913, to July 19, 1913, that I last saw him alive on July 12, 1913, and that death occurred, on the date stated above, at p.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
50
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) M. F. Wright M. D.
July 10, 1913 (Address) Knox City 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 Harrison Brooks Cemetery DATE OF BURIAL July 13, 1913
UNDERTAKER J. B. Conley ADDRESS Bullodge Mo

N. 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.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____
 Primary Registration District No. _____

File No. _____
 Registered No. _____

(NO. _____ St. _____ Ward _____)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
 COLOR OR RACE _____
 SINGLE _____
 MARRIED _____
 WIDOWED _____
 OR DIVORCED _____
 (Write the word)

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

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

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

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

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

Filed _____, 191_____, _____ REGISTRAR

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

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.

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____,
 that I last saw h_____ alive on _____, 191_____,
 and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Address) _____ M. D.

*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 _____ DATE OF BURIAL _____, 191_____
 UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERSISTENT RECORD.

N. B.—Every item of this form should be filled in. If the age of the deceased is not stated, the age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in all instances, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
 County Moxy
 Township Colony Registration District No. 1056 File No. 14
 or
 Village _____ Primary Registration District No. 5594 Registered No. 14
 or
 City _____ (NO. _____ St.: _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John Lewis Gardner.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF RACE White SINGLE Married
 MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ min.
 OCCUPATION (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 BIRTHPLACE (City or town, State or foreign country) _____
 PARENTS
 NAME OF FATHER _____
 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
 MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h_____ alive only _____, 191____,
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
caused by jumping into cold
water while hot
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 Signed Dr. F. Wright M.D.
July 12, 1913 (Address) Moxy City, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory Information Supplied.

(ADDRESS) _____
 Filed July 12, 1913 C. E. Hoffman REGISTRAR

PLACE OF BURIAL OR REMOVAL Herman's
 DATE OF BURIAL July 13, 1913
 UNDERTAKER J. R. Canley
 (Address) _____
Satisfactory Information Supplied.

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*, *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 septicæmia," "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.)