

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.

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

PLACE OF DEATH

County Polk
Township Lacey
or
Village Morristown
or
City _____ (NO. _____ St. _____ Ward)

110

Registration District No. 704 File No. 2952

Primary Registration District No. 4425 Registered No. 20

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

FULL NAME James Mitchell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED MARRIED WIDOWED WIDOWED OR-SWORN OR-SWORN (Write the word)

DATE OF DEATH Jan 2, 1910
(Month) (Day) (Year)

DATE OF BIRTH June 16, 1840
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 27, 1910, to Jan 1, 1910, that I last saw him alive on Jan 1, 1910, and that death occurred, on the date stated above, at 1, a m.

AGE 70 yrs. 6 mos. 15 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Paralysis of bowels
14 30 P
16 2

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 11-15-1910

BIRTHPLACE (City or town, State or foreign country) Polk Co Mo

NAME OF FATHER M. R. Mitchell

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

MAIDEN NAME OF MOTHER

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

(Duration) ___ yrs. ___ mos. 5 ds.

Contributory Senility
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H. G. Miller M. D.
Jan 2, 1910 (Address) Morristown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(Informant) Edwin F. Mitchell

Where was disease contracted if not at place of death?

(ADDRESS) Morristown Mo

Former or usual residence

Filed Jan 31, 1910

PLACE OF BURIAL OR REMOVAL Morristown DATE OF BURIAL Jan 3, 1910

UNDERTAKER Prof. Jones ADDRESS Morristown

REGISTRAR

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*, *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.)



C. 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.

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Perk
Township _____
or
Village Morrisville
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 704- File No. 2952
Primary Registration District No. 4425 Registered No. _____

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

FULL NAME James Mitchell

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>6/16</u> , 18 <u>40</u> (Month) (Day) (Year)		
AGE <u>70</u> yrs. <u>6</u> mos. <u>15</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) 1-2- (Day) 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from 1/27, 1910, to 1-1-, 1911, that I last saw him alive on 1-1-, 1911, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:
Paralysis of Bowels.

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

PARENTS

NAME OF FATHER <u>M. R. Mitchell</u>	(Duration) _____ yrs. _____ mos. _____ ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Penn. X</u>	Contributory <u>Scrub</u> (SECONDARY)
MAIDEN NAME OF MOTHER <u>Anna Living</u>	(Duration) _____ yrs. _____ mos. _____ ds.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Penn. X</u>	(Signed) <u>W. S. Miller</u> M.D. <u>1-2-</u> , 19 <u>11</u> (Address) <u>Morrisville, Mo.</u>

*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 _____ yrs. _____ mos. _____ ds. 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) Elmer F. Mitchell
(ADDRESS) Morrisville, Mo.

PLACE OF BURIAL OR REMOVAL <u>Morrisville</u>	DATE OF BURIAL <u>1-3-</u> , 19 <u>11</u>
UNDERTAKER <u>J. W. Thompson</u>	ADDRESS <u>Morrisville</u>

Filed Jan 31 1911 by P. A. M. Reynolds
REGISTRAR

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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