

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important.

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

PLACE OF DEATH

County Cole
 Township _____
 or
 Village _____
 or
 City JEFFERSON CITY, MO. (NO. 316 - Locust St. 3rd Ward)

Registration District No. 213 File No. 17314
 Primary Registration District No. 3014 Registered No. 80

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

FULL NAME Marsh D. Stone

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOUR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u>
DATE OF BIRTH <u>Feb. 7, 1875</u> (Month) (Day) (Year)		AGE <u>36</u> yrs. <u>3</u> mos. <u>17</u> ds.
OCCUPATION (a) Trade, profession, or particular kind of work <u>General work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>113-001</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Jefferson City, Mo.</u>		
PARENTS	NAME OF FATHER <u>John Stone</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Cole Co., Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Margaret Hackney</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Monticello Co., Mo.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Andy Knerusch
 (ADDRESS) Jefferson City, Mo.
 Filed May 25 1914 Walter Amundson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 24, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 23, 1914, to May 24, 1914, that I last saw him alive on May 24, 1914, and that death occurred, on the date stated above, at 7 am

The CAUSE OF DEATH was as follows:
Stroke due to
brain injury
from a head
injury
1914 (Duration) 20 hrs. 00 mos. 00 ds.

Contributory (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) C. G. P. P. P. M. D.
May 25, 1914 (Address) Jefferson 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 <u>City Cemetery</u>	DATE OF BURIAL <u>5/26</u> 191 <u>4</u>
UNDERTAKER <u>Walter Amundson</u>	ADDRESS <u>J. C. Mo.</u>

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.)



PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

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

Township _____

Registration District No. _____

File No. 17314

Village _____

Primary Registration District No. _____

Registered No. _____

City J.C. (NO. _____)

St. _____ Ward _____

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

FULL NAME

Marion D Stone

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1911
(Month) 5 (Day) 24 (Year)DATE OF BIRTH _____, _____, 191_____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____,

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

that I last saw him alive on _____, 191_____,

and that death occurred, on the date stated above, at _____ m.

OCCUPATION (a) Trade, profession, or particular kind of work _____

The CAUSE OF DEATH* was as follows:

(b) General nature of industry, business, or establishment in which employed (or employer) _____

injury
Accidental
and was hit with a piece of wood on
from a bench
Contributory

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

(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER _____

(Signed) C. H. Stone M. D.

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

MAIDEN NAME OF MOTHER _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) _____ Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

Filed _____ 191____ REGISTRAR _____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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