

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 Gasper
Township J. Plino
or
Village
or
City Cartersville (NO. N. Kenn St.; _____ Ward)

Registration District No. 407 File No. 28520

Primary Registration District No. 4241 Registered No. 46

FULL NAME

John W. Swift

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH August 15th 1911
(Month) (Day) (Year)

DATE OF BIRTH Jan 13, 1875
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 18th, 1910, to Aug 15th, 1911, that I last saw him alive on August 15th, 1911, and that death occurred, on the date stated above, at 9⁴⁵ m.

AGE 36 yrs. 7 mos. 3 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) 5-29

1876
Chronic Lung Disease
Chronic Bronchial Pneumonia
(Duration) _____ yrs. 10 mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Mo.

Contributory mine work
(SECONDARY) (Duration) _____ yrs. 10 mos. _____ ds.

PARENTS NAME OF FATHER W. H. Swift

(Signed) W. E. Dumbauld M. D. (Address) Cartersville Mo.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known

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

MAIDEN NAME OF MOTHER Eliza Geckstraw

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

Where was disease contracted if not at place of death? at place of death
Former or usual residence Dallas Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jno W. Swift
(ADDRESS) Cartersville Mo.

PLACE OF BURIAL OR REMOVAL W. Hope Cem. DATE OF BURIAL Aug 20 1911

Filed Aug 18 - 1911 Registrar W. W. C. Lewis

UNDERTAKER Webb City Ind. Co. ADDRESS Webb City 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*, *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.)



PLACE OF DEATH

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

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

County Jasper Registration District No. 407 File No. _____
 Township _____ or Village Carterville Primary Registration District No. 4241 Registered No. 46
 City Carterville (No. 11 Kenn) St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John W. Swift

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M.
 DATE OF BIRTH Jan. 13, 1875
 (Month) (Day) (Year)
 AGE 36 yrs. 7 mos. 5 ds. IF LESS than 1 day, hrs. or min.
 OCCUPATION (a) Trade, profession, or particular kind of work Miner.
 (b) General nature of industry, business, or establishment in which employed (or employer) Undershafted
 BIRTHPLACE (City or town, State or foreign country) W. Va.
 NAME OF FATHER H. J. Swift
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
 MAIDEN NAME OF MOTHER Rebecca
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mr. J. W. Swift
 (ADDRESS) Carterville, Mo.
 Filed Aug 19, 1911 REGISTERAR J. W. McCloud

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8 - 18, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Aug 19, 1910, to 8-18, 1911,
 that I last saw him alive on 8-18, 1911
 and that death occurred, on the date stated above, at 9:45 a.m.
 The CAUSE OF DEATH* was as follows:
Miners Lung Disease
Chronic Bronchial Pneumonia
 (Duration) yrs. mos. ds.
 Contributory None None
 (SECONDARY)
 (Duration) yrs. mos. ds.
 (Signed) H. O. Dumbault M. D.
8-18 (1911) (Address) Carterville Mo.
 *State the Disease Causing Death, or, in deaths from Violent Causes, state 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 W. Slope Cem. DATE OF BURIAL 8-20, 1911
 UNDERTAKER W. H. City ADDRESS Mo. City

Revised United States Standard Certificate of Death

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

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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.)

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