

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

PLACE OF DEATH

County Marion
Township Union
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 549 File No. 32008
Primary Registration District No. 4444 Registered No. 10
5742

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

FULL NAME John C Craine

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Don't know, 1 _____ (Month) _____ (Day) _____ (Year)

AGE About 40 yrs. _____ mos. _____ 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) 1-42

BIRTHPLACE (City or town, State or foreign country) Marion Co

PARENTS
NAME OF FATHER John Craine
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Reb Craine
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Craine x

(ADDRESS) _____
Filed Sept 9 1911 C. F. Craine REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 4, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 2, 1911, to Sept 2, 1911, that I last saw him alive on Sept 2, 1911, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
13A
28
(Duration) 1 yrs. 6 mos. _____ ds.

Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 1911 (Address) _____

*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 Little Union DATE OF BURIAL Sept 5 1911
UNDERTAKER Craine & Son ADDRESS Polysa Me

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD

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.

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.)



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

PLACE OF DEATH
 County Marion
 Township Union
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 549 File No. _____
 Primary Registration District No. 5742 Registered No. 10

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

FULL NAME John C. Crane

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED single WIDOWED OR DIVORCED
(Write the words)

DATE OF DEATH Sept 4, 1911
(Month) (Day) (Year)

DATE OF BIRTH Sept 2, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 2, 1911, to Sept 2, 1911, that I last saw him alive on Sept 2, 1911, and that death occurred, on the date stated above, at 6 m.

AGE about 40 yrs. mos. 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 Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

Pulmonary Tuberculosis
sic

BIRTHPLACE (City or town, State or foreign country) Marion Co

(Duration) 1 yrs. 6 mos. ds.

NAME OF FATHER John Crane

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

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

(Signed) R. B. Nipton M. D.
Sept 9, 1911 (Address) Philadelphia

MAIDEN NAME OF MOTHER Est. Crane

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

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

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
 (Informant) N. D. Crane x

Where was disease contracted if not at place of death? _____
 Former or usual residence _____

(ADDRESS) Philadelphia

PLACE OF BURIAL OR REMOVAL Little Union DATE OF BURIAL Sept 5, 1911

Filed Sept 9, 1911 R. B. Nipton REGISTRAR

UNDERTAKER Zuest & Son ADDRESS Palmyra, Mo.

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

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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32002