

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 New Madrid
Township Hatch Registration District No. 603 File No. 35337
or
Village _____ Primary Registration District No. 4357 Registered No. 45
or
City Morehouse Mo (NO. _____ St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME, John Thomas Duncan

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single MARRIED WIDOWED OR DIVORCED (If wife the word)
DATE OF BIRTH Aug-19, 1911 (Month) (Day) (Year)
AGE 33 yrs. 5 mos. 26 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 19, 1911 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from July-19, 1911, to Aug-19, 1911, that I last saw him alive on Aug-19, 1911, and that death occurred, on the date stated above, at 8:09 m.
The CAUSE OF DEATH* was as follows:
Acute Dysentery 14
13 yrs (Ulcerative colitis, Bloody flux)
17 yrs (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Bowl Beer (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. McKinney M. D. Aug 20, 1911 (Address) Morehouse Mo
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE (City or town, State or foreign country) Obion Co Tennessee

PARENTS
NAME OF FATHER John H. Duncan
BIRTHPLACE OF FATHER (City or town, State or foreign country) Davis Co Kentucky
MAIDEN NAME OF MOTHER Lucy Haines
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Davis Co Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Bowdle
(ADDRESS) Morehouse Mo

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 _____

Filed Oct 9 1911 J. C. Hayhurst REGISTRAR

PLACE OF BURIAL OR REMOVAL Sikeston DATE OF BURIAL _____ 1911
UNDERTAKER Marshall Harrison ADDRESS Morehouse

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, peritonaeum*, 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.)



County New Madrid Registration District No. 603 File No. _____
 Township _____ or Village _____ or City Morehouse MO. Primary Registration District No. 435-7 Registered No. 45
 St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John Thomas Dineen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 19, 1911
(Month) (Day) (Year)

DATE OF BIRTH July 19, 1878
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from July 19, 1911, to Aug 19, 1911;
 that I last saw him live on Aug 19, 1911,

AGE 33 yrs. 5 mos. 26 ds. IF LESS than 1 day, _____ hrs. or _____ min. ?

and that death occurred, on the date stated above, at 8 P. m.
 The CAUSE OF DEATH* was as follows:

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

Acute Dysentery
Ulcerative colitis
Blood flux

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

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Bowel Ulcers

NAME OF FATHER J. M. Dineen

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. J. McKinney M. D.

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

(Address) Morehouse
 *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 Lacey Haines

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Julia Bowdle
 (ADDRESS) Morehouse Mo

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

Filed Aug 1 1911 J. O. Hayhurst REGISTRAR

PLACE OF BURIAL OR REMOVAL Nikeston DATE OF BURIAL Aug 20, 1911

UNDERTAKER Marshall & Hare ADDRESS Morehouse

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 *septichaemia*," "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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