

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty Ralls Co. Mo.Township Jasper.Registration District No. 727File No. 42397

Village \_\_\_\_\_

Primary Registration District No. 5960Registered No. 32

City \_\_\_\_\_ (NO. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Jephtha Burch

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)DATE OF BIRTH Nov. 24, 1945  
(Month) (Day) (Year)AGE 65 yrs. 11 mos. 28 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?OCCUPATION (a) Trade, profession, or particular kind of work Labourer  
(b) General nature of industry, business, or establishment in which employed (or employer) 3-67BIRTHPLACE (City or town, State or foreign country) Rike Co. Mo.PARENTS  
NAME OF FATHER Geo. W. Burch  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky.  
MAIDEN NAME OF MOTHER Ford  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben S Burch(ADDRESS) Vandalia Mo.Filed Dec 9<sup>th</sup> 1911 F. Walter  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 21<sup>st</sup>, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov 6, 1911, to Nov 14, 1911, that I last saw him alive on Nov 14, 1911, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

Heart disease  
74  
(Duration) \_\_\_ yrs. 4 mos. \_\_\_ ds.

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) J. H. Weingarten M. D.  
Nov 21, 1911 (Address) Vandalia 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. 4 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 Vandalia Mo. DATE OF BURIAL Nov. 22, 1911UNDERTAKER J. B. Clark ADDRESS Vandalia 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.)



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 Ralls  
Township Jasper  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 727 File No. \_\_\_\_\_  
Primary Registration District No. 5960 Registered No. 32

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

FULL NAME John Jephtha Burch

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov. 24, 1845  
(Month) (Day) (Year)

AGE 65 yrs. 11 mos. 28 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) \_\_\_\_\_

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

PARENTS NAME OF FATHER Geo. W. Burch BIRTHPLACE OF FATHER Ky.  
MAIDEN NAME OF MOTHER Ford BIRTHPLACE OF MOTHER Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ben S. Burch

(ADDRESS) Vandalia Mo.

Filed See 9<sup>th</sup> of 1 F. Walter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 21, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 6, 1911, to Nov. 14, 1911, that I last saw him alive on Nov. 14, 1911, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:  
Myocardial Infarction

(Duration) 4 yrs. 4 mos. 0 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) 0 yrs. 0 mos. 0 ds.  
(Signed) Geo. Hallingworth M. D. Nov. 21, 1911 (Address) Vandalia, 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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

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

PLACE OF BURIAL OR REMOVAL Vandalia Mo. DATE OF BURIAL Nov. 27, 1911

UNDERTAKER J. B. Clark ADDRESS Vandalia Mo.

# 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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