

PLACE OF DEATH

County CallawayTownship Cote Sans Dessein Registration District No. 111

or

Village _____ Primary Registration District No. 5161

or

City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHFile No. 4397

Registered No. _____

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

FULL NAME Joseph A. Dearing

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)DATE OF BIRTH June 9, 1839
(Month) (Day) (Year)AGE 72 yrs. 7 mos. 22 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) 1-02BIRTHPLACE
(City or town, State or foreign country) VirginiaNAME OF FATHER Joseph B. DearingBIRTHPLACE OF FATHER
(City or town, State or foreign country) Va.MAIDEN NAME OF MOTHER Arthenia J. WallaceBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. M. Hopkins(ADDRESS) Sebetta, Mo.Filed Feb 2 1912 G. P. Rootes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 31, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan. 28, 1912, to Jan. 31, 1912, that I last saw him alive on Jan. 31, 1912,and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
82 A
99 (Duration) - yrs. - mos. 4 ds.

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

(Signed) G. P. Rootes M. D.
Jan 31, 1912 (Address) Sebetta 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 4 yrs. - mos. - ds. in the 70 yrs. - mos. - ds. State _____

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL River View Cem. Sebetta, Mo. DATE OF BURIAL Feb 1, 1912UNDERTAKER R. Meyer ADDRESS Sebetta Mo.

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*, *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, peritonacum*, 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 Callaway
 Township lecti Sans Dessein
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 111 File No. 4397
 Primary Registration District No. 5161 Registered No. _____

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

FULL NAME Joseph A. Dearing

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED W.
 (Write the word)
 DATE OF BIRTH June 9, 1839
 (Month) (Day) (Year)
 AGE 72 yrs. 7 mos. 22 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) _____
 BIRTHPLACE (City or town, State or foreign country) Virginia

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 31, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Jan. 28, 1912, to Jan. 31, 1912,
 that I last saw him alive on 4 " , 1916,
 and that death occurred, on the date stated above, at 9:20P.M.
 The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Atherosomatous degeneration
of the arteries.
 (Duration) _____ yrs. _____ mos. 4 ds.

PARENTS
 NAME OF FATHER Jos. B. Dearing
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.
 MAIDEN NAME OF MOTHER Parthenia J. Wallace
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

Contributory (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) G. B. Rootes M. D.
Mar. 9, 1912 (Address) Tebbetts Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. E. W. Hopkins
 (ADDRESS) Tebbetts Mo.
 Filed Mar. 9, 1912 G. B. Rootes
 REGISTRAR

* 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 Primer New Cem. DATE OF BURIAL Feb. 1st, 1912
 UNDERTAKER A. Meyer ADDRESS Tebbetts Mo.

Revised United States Standard Certificate of Death

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

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