

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

N. B.—Every item of information should be carefully supplied. PAGE 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 Scott  
Township Sylvania Registration District No. 720 File No. 3768  
or  
Village \_\_\_\_\_ Primary Registration District No. 6069 Registered No. 3  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Joseph Watts

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male COLOR OR RACE \_\_\_\_\_  
MARRIED yes  
WIDOWED \_\_\_\_\_  
OR DIVORCED \_\_\_\_\_  
(Write the word)

DATE OF BIRTH Jan 30 1892  
(Month) (Day) (Year)

AGE 39 yrs. 11 mos. 12 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) Farmer

BIRTHPLACE (City or town, State or foreign country) Scott Co mo

NAME OF FATHER Char Watts

BIRTHPLACE OF FATHER (City or town, State or foreign country) Scott Co Mo

MAIDEN NAME OF MOTHER Mary Hugler

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Scott Co mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Chas Watts

(ADDRESS) Cran Mo

Filed 2/9 1912 H. G. Ginn REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Nov 12 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 9, 1911, to Nov 12, 1911, that I last saw him alive on Nov 12, 1911, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia  
103

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

(Signed) J. H. Hessemer M. D.  
Dec 29 1911 (Address) Cran 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. \_\_\_ 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 Cran Mo DATE OF BURIAL Nov 13 1911

UNDERTAKER T. S. Hessemer ADDRESS Cran Mo

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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

County.....  
 Township..... Registration District No..... File No.....  
 or Village..... Primary Registration District No.....  
 or City.....(NO.....) St..... Ward.....  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX.....  
 COLOR OR RACE.....  
 DATE OF BIRTH..... (Month)..... (Day)..... (Year).....  
 AGE..... yrs..... mos..... ds. IF LESS than 1 day,..... hrs. or..... min.?

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

BIRTHPLACE  
 (City or town, State or foreign country)

**PARENTS**  
 NAME OF FATHER.....  
 BIRTHPLACE OF FATHER (City or town, State or foreign country).....  
 MAIDEN NAME OF MOTHER.....  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country).....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant).....  
 (ADDRESS).....  
 Filled..... 191..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH..... (Month)..... (Day)..... (Year)..... 191.....  
 I HEREBY CERTIFY, that I attended deceased from....., 191....., to....., 191.....  
 that I last saw h..... alive on....., 191....., and that death occurred, on the date stated above, at..... in.....  
 The CAUSE OF DEATH\* was as follows:

..... (Duration)..... yrs..... mos..... ds.  
 ..... (Duration)..... yrs..... mos..... ds.  
 ..... (Signed)..... M. D.

**Contributory**  
 (SECONDARY)

..... 191..... (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. State..... yrs..... mos..... ds.  
 Where was disease contracted if not at place of death?  
 Former or usual residence.....

PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL..... 191.....  
 UNDERTAKER..... ADDRESS.....

## PLACE OF DEATH

County Scott  
 Township Sylvania  
 or  
 Village  
 or  
 City (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

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

Registration District No. 820 File No. 7768  
 Primary Registration District No. 6069 Registered No. 3

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

FULL NAME

Joseph Watts

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>eyes</u>
DATE OF BIRTH <u>Jan. 30</u> , 18 <u>72</u> (Month) (Day) (Year)		
AGE <u>39</u> yrs. <u>11</u> mos. <u>12</u> ds. If LESS than 1 day, hrs. or min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Scott Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Chas. Watts</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scott Co. Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Mary Hughes</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scott Co. Mo.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Obie Watts</u> (ADDRESS) <u>Oran Mo.</u>		
Filed <u>219</u> 19 <u>12</u> <u>R. B. Glenn</u> REGISTRAR		

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH <u>Nov-12</u> , 19 <u>11</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Nov-9</u> , 19 <u>11</u> , to <u>Nov-12</u> , 19 <u>11</u> , that I last saw him alive on <u>Nov-12</u> , 19 <u>11</u> , and that death occurred, on the date stated above, at <u>2 P.</u> m.	
The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u>	
(Duration) _____ yrs. _____ mos. _____ ds.	
Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>W. H. Wescoat</u> * M. D. <u>Dec. 29, 1912</u> (Address) <u>Oran Mo.</u>	
*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 <u>Evans Graveyard</u>	DATE OF BURIAL <u>Nov-13</u> , 19 <u>11</u>
UNDERTAKER <u>J. S. Hemmer</u>	ADDRESS <u>Oran Mo.</u>

Original file, date \_\_\_\_\_, 19\_\_\_\_

All information called for must be written on this Supplementary Certificate.

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 IS A PERMANENT RECORD

# 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.)