

WRITE PLAINLY, WITH UNFADING 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH **12057**
11957

PLACE OF DEATH _____ V

County Adair Registration District No. 4 File No. _____

Township _____ or _____ Primary Registration District No. 3001 Registered No. 45

Village _____ or _____ City Kirkville (NO. 620 Jefferson St., 4 Ward)

FULL NAME John S. Powell

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

PERSONAL AND STATISTICAL PARTICULARS V MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED married WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH 4 8, 1913
(Month) (Day) (Year)

DATE OF BIRTH 9 12, 1857
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4-7-, 1913, to 4-8-, 1913, that I last saw him alive on 4-7-, 1913, and that death occurred, on the date stated above, at 1:30 m.

AGE 55 yrs. 6 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

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

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Arterio Sclerosis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Waverly Mo

(Signed) O. B. Ballison M. D.
4-8-, 1913 (Address) Kirkville

PARENTS NAME OF FATHER John Powell

*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 FATHER _____

MAIDEN NAME OF MOTHER Sarah Pugh

BIRTHPLACE OF MOTHER Ind. near Hillsville

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 _____

(Informant) Rose Powell

(ADDRESS) Kirkville Mo

PLACE OF BURIAL OR REMOVAL Forest Park DATE OF BURIAL 4-10-, 1913

Filed 4-8-, 1913 O. B. Ballison REGISTRAR

UNDERTAKER H. C. Wilson ADDRESS Kirkville

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 _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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	SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word)
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DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

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 _____ m. The CAUSE OF DEATH* was as follows:

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

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

Contributory _____ (Signed) _____ (Address) _____, 191____, M. D.

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)

_____ (Date of Burial or Removal)

_____ (Date of Burial)

_____ (Address)

_____ (Address)

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

REGISTRAR _____

Filed _____, 191____

*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 _____

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

N. P.—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 Adair

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

Township

Registration District No. 4

File No.

Village

Primary Registration District No. 3001

Registered No.

City

Nirksville

(NO. 020 E. Jefferson St., 4 Ward)

Registered No.

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

FULL NAME

John S. Howard Powell

PERSONAL AND STATISTICAL PARTICULARS

SEX

m

COLOR OR RACE

w

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

m

DATE OF BIRTH

9

12

1857

(Month)

(Day)

(Year)

AGE

55 yrs. 6 mos. 16 ds.

If LESS than 1 day, ___ hrs or ___ min.

OCCUPATION

(a) Trade, profession, or particular kind of work

Leement Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

Building

BIRTHPLACE

(City or town, State or foreign country)

Adair Co. Mo.

NAME OF FATHER

Chas. Powell

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ill.

MAIDEN NAME OF MOTHER

Sarah Butts

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ind. near Chillicothe

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. E. Ballison

(ADDRESS)

Nirksville Mo.

Filed

4-8

1913

Wm. E. Ballison

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

4

8

1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied, to _____, 1913,

that I last saw h _____ alive on _____, 1913,

and that death occurred, on the date stated above at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

_____ M. D.

(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 _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence Satisfactory Information Supplied

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

UNDERTAKER

ADDRESS

Original file, date _____, 19_____

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

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 *Nona*.

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*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

12057
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.)