

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

PLACE OF DEATH
County Crawford
Township _____
or _____
Village Bourbon
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 229 File No. 22459
Primary Registration District No. 4139 Registered No. 12

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

FULL NAME John Farmer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH Oct 15 1893
Not known to family
(Month) (Day) (Year)

AGE 39 yrs. 8 mos. 22 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) 1-0-2

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

PARENTS
NAME OF FATHER Not known to family
BIRTHPLACE OF FATHER Not known to family
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Not known to family
BIRTHPLACE OF MOTHER Not known to family
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. R. Farmer

(ADDRESS) Kirkwood, Mo

Filed July 11 1913 E. L. Humes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 10 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1913, to July 10, 1913, that I last saw him alive on July 8, 1913, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:
Paralysis
167
82 17
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) E. L. Humes M. D.
July 11 1913 (Address) Bourbon, 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 Bourbon, Mo. DATE OF BURIAL July 11 1913

UNDERTAKER none ADDRESS _____

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, 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 *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; Sarcoma*, 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.)

PLACE OF DEATH
 County Crawford
 Township Bourbon
 or
 Village Bourbon
 or
 City _____ (NO _____ St.: _____ Ward)

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

Registration District No. 229 File No. _____
 Primary Registration District No. 4139 Registered No. 12 ✓

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

FULL NAME John Farmer.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OF RACE white SINGLE married
 MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ yrs. _____ mos. _____ ds. If LESS than _____ day, _____ hrs. _____ min. _____ sec.
 OCCUPATION (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employed by) _____

DATE OF DEATH July 10, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, _____ m.

The CAUSE OF DEATH* was as follows:
Paralysis of the pharynx due to cerebral hemorrhage, a sequel of arteriosclerosis and advanced age.
 (Duration) _____ mos. 10 ds.

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) E. R. Hume M. D.
July 11, 1913 (Address) Bourbon, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
 UNDERTAKER _____

Filed July 11, 1913 E. R. Hume REGISTRAR

SUPPLEMENTARY Satisfactory Information Supplied.

Satisfactory Information Supplied.

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