

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**

PLACE OF DEATH

County Butler
Township Blackriver
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 91
Primary Registration District No. 5735

File No. 38741
Registered No. 15

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

FULL NAME Joseph Porsch

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>Feb 19, 1878</u> (Month) (Day) (Year)		

AGE
75 yrs. 9 mos. 28 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 work

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

PARENTS	NAME OF FATHER <u>Wm Porsch</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>
	MAIDEN NAME OF MOTHER <u>Unknown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri Co, Tenn</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carle Fare
(ADDRESS) Hendrickson Mo

Filed Dec 19, 1913 Lee Harwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 17, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 16, 1913, to Dec 17, 1913, that I last saw him alive on Dec 17, 1913, and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia
1074
11:30
(Duration) ___ yrs. ___ mos. 3 ds.

Contributory Age
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J Lee Harwell M. D.
Dec 18, 1913 (Address) Hendrickson 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 <u>Blackriver Cem</u>	DATE OF BURIAL <u>Dec 19, 1913</u>
UNDERTAKER <u>W. Ross</u>	ADDRESS

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.)



PLACE OF DEATH

County

Butter

Township

Black River

or

Village

or

City

REGISTRARS SHALL NOT RECEIVE 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.

91

File No.

Primary Registration District No.

5135

Registered No.

15

(NO.

St.:

Ward)

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

FULL NAME

Joseph Poch

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

*w*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*m*

DATE OF BIRTH

_____, 1_____, 1_____
(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)

Filed

12/18 3 J. Lee Harwell

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 17 3
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from *Dec 17*, 191*2*, to *Dec 17*, 191*2*, that I last saw him alive on *Dec 17*, 191*2*, and that death occurred, on the date stated above, at *11:30* a.m. The CAUSE OF DEATH* was as follows:*Pneumonia*
Broncha Pulmonia(Duration) yrs. mos. ds. *3*

Contributory

(SECONDARY)

(Duration) yrs. mos. ds. *apr*(Signed) *J. Lee Harwell* M. D.*12/18 1913* (Address) *Heudrichsm*

*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

DATE OF BURIAL

UNDERTAKER

ADDRESS

Original file, date

DEC - 1913

19

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

MARGIN RESERVED FOR

V. S. No. 2.

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it can be verified. Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

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

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