

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.

New Wells

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

PLACE OF DEATH

County Green

Township _____

Village _____

City Springfield

Registration District No. 318

Primary Registration District No. 2001

(NO. 810 S Grant St. Ward)

File No. 8204

Registered No. 318-172

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

FULL NAME Mrs J. J. Inmon (Nau)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH March 15, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 1860
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 7, 1914, to March 15, 1915, that I last saw her alive on March 15, 1915, and that death occurred, on the date stated above, at 4 P m.

AGE 54 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Pneumonia follow
measles

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

(Duration) 10 1/2 yrs. about 14 mos. 14 ds.

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

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

NAME OF FATHER Jones

(Signed) A. E. Inmon M. D.
March 15, 1915 (Address) 201 W. Walnut St.

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

MAIDEN NAME OF MOTHER blout know

* 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 MOTHER (City or town, State or foreign country) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. J. Inmon

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) Battleyfield #1

PLACE OF BURIAL OR REMOVAL Batterson Cem DATE OF BURIAL March 16, 1915

Filed Mar 15, 1915 D. C. W. Smith REGISTRAR

UNDERTAKER W. C. Schreyer ADDRESS 300 W. Walnut

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, peritoneum*, 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

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

County Iron

Township _____

Registration District No. 318

File No. _____

or Village _____

Primary Registration District No. 2001

Registered No. 172

or City Springfield (NO. 810 S Grant)

St. _____ Ward _____

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

FULL NAME J. J. Inmon

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

DATE OF DEATH

3/15, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____

(Month) (Day) (Year)

AGE _____

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

that I last saw h. _____ alive on _____, 1914, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia followed by Broncho Pneumonia

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) _____

(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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(ADDRESS) _____

Filed 3/15, 1914

REGISTRAR

Contributory Asthma

(SECONDARY)

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

(Signed) H. A. Hill

3/15, 1914 (Address) _____ M. O. _____

*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 _____ 1914

UNDERTAKER _____

ADDRESS _____

Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly understood.

Satisfactory Information Supplied.

Supplementary Certificate

Revised United States Standard Certificate of Death

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

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