

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 Johnson
Township _____
or
Village Warrensburg
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 431 File No. 16472
Primary Registration District No. 3023 Registered No. 32

FULL NAME Willard Filmore Stillwell

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>May 8</u> , 19 <u>14</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>February 15</u> , 1 <u>852</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>April 1</u> , 19 <u>14</u> , to <u>May 8</u> , 19 <u>14</u> , that I last saw him alive on <u>May 7</u> , 19 <u>14</u> , and that death occurred, on the date stated above, at <u>4:12</u> p.m. The CAUSE OF DEATH* was as follows: <u>Septic endocarditis</u> <u>5 1/2</u> <u>9 1/2</u> (Duration) <u>78</u> yrs. <u>2</u> mos. <u>0</u> ds.	
AGE <u>52</u> yrs. <u>2</u> mos. <u>23</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?			Contributory _____ (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. (Signed) <u>James S. Anderson</u> M. D. <u>May 9</u> , 19 <u>14</u> . (Address) <u>Warrensburg Mo</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Plumber</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Plumbing</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
BIRTHPLACE (City or town, State or foreign country) <u>Paris, Ill.</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
PARENTS	NAME OF FATHER <u>Elias Stillwell</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Massland</u>		PLACE OF BURIAL OR REMOVAL <u>City Cem.</u>	
	MAIDEN NAME OF MOTHER <u>Mary Ann Harrick</u>		DATE OF BURIAL <u>May 9</u> , 19 <u>14</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>		ADDRESS <u>J. M. McKin</u> <u>Warrensburg Mo.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R. R. Stillwell</u> (ADDRESS) <u>Pleasant Hill Mo</u>			UNDERTAKER <u>J. M. McKin</u>	
Filed <u>May 9</u> , 19 <u>14</u> . <u>H. Parker</u> REGISTRAR				

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 septicæmia," "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.)

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

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PLACE OF DEATH
County Johnson
Township _____
Village _____
or _____
City Warrensburg (NO. _____ St. _____ Ward _____)

Registration District No. 431 File No. _____
Primary Registration District No. 3023 Registered No. 32

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

FULL NAME Millard Filmore Stittwell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M
(Write the word)

DATE OF DEATH May 8, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, 191
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914 to _____, 1914,
that I first saw him _____, 1914,
and that death occurred, on the date stated above, at _____ m.

AGE _____ yrs. _____ mo. _____ ds.
If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Septic Endorontitis
Rheumatism

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) _____

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) James A. Anderson M. D.
May 9, 1914 (Address) Warrensburg

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) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 3 yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted If not at place of death? _____
Former or usual residence _____

Filed May 9, 1914 J. F. Parker
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1914
UNDERTAKER _____ ADDRESS _____

MAY 1914

Revised United States Standard Certificate of Death

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