

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

35754

1 PLACE OF DEATH  
County Jasper  
Township .....  
or  
Village .....  
or  
City Joplin Mo (NO. 722 Na Byers St., 7 Ward)

Registration District No. 411 File No. ....  
Primary Registration District No. 2002 Registered No. 485

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

2 FULL NAME William R. Moses

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Mar. 18 1867  
(Month) (Day) (Year)

7 AGE 47 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Life Insurance  
(b) General nature of industry business, or establishment in which employed (or employer) Manager

9 BIRTHPLACE Canada  
(City or town, State or foreign country)

PARENTS  
10 NAME OF FATHER James Moses  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Canada  
12 MAIDEN NAME OF MOTHER Marion Green  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs W. R. Moses  
(Address) Joplin Mo.

15 Filed Nov. 13 1914 A. M. Gregg Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 11 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 2, 1914, to Nov. 11, 1914, that I last saw him alive on Nov. 11, 1914, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH\* was as follows:

93 A Myocarditis  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) A. H. Neal M. D. (Address) Joplin Mo.  
118 13, 1914

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

18 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

19 PLACE OF BURIAL OR REMOVAL Mount Hope DATE OF BURIAL Nov. 13 1914

20 UNDERTAKER Frank Myers Co ADDRESS Joplin Mo.

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*, *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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH Joplin  
 County Joplin Registration District No. 411 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_ or \_\_\_\_\_ Primary Registration District No. 3002 Registered No. 485  
 City Joplin (NO. 722 N Bys St.; 7 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME William R. Moses

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>W</u> (Write the word)	DATE OF DEATH <u>11/11</u> , 191 <u>4</u> (Month) (Day) (Year)
DATE OF BIRTH _____ (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____ <u>Satisfactory Information Supplied.</u> , 191 <u>4</u> , that I last saw h. _____ alive on _____, 19 <u>14</u> , and that death occurred, on the date stated above, at _____ m.
AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. _____ min.	THE CAUSE OF DEATH* was as follows: <u>Myocarditis (Acute)</u> <u>78</u>
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.
BIRTHPLACE (City or town, State or foreign country) _____			Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
PARENTS	NAME OF FATHER _____		(Signed) <u>A. M. Gregg</u> M.D. <u>11/13</u> , 191 <u>4</u> (Address) <u>Joplin Mo</u>
	BIRTHPLACE OF FATHER (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.
	MAIDEN NAME OF MOTHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		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) _____			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191 <u>4</u>
(ADDRESS) _____			UNDERTAKER _____ ADDRESS _____
Filed <u>11/13</u> , 191 <u>4</u> <u>A. M. Gregg</u> REGISTRAR			

NOV 1914

Original file, date \_\_\_\_\_, 19\_\_\_\_ All information called for must be written on this Supplementary Certificate.

Attention should be carefully given to the following instructions: 1. The name of the deceased should be stated EXACTLY. 2. Physicians should state EXACTLY the cause of death. 3. Exact statement of OCCUPATION is very important. 4. The date of death should be stated in plain terms, so that it may be clearly understood. 5. The cause of death should be stated in plain terms, so that it may be clearly understood. 6. The name of the informant should be stated. 7. The name of the informant should be stated. 8. The name of the informant should be stated. 9. The name of the informant should be stated. 10. The name of the informant should be stated.

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