

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County *Jasper*
 Township
 or
 Village
 or
 City *Joplin*

Registration District No. *411* File No. **1405**
 Primary Registration District No. *2002* Registered No. *564*
 (NO. *Royal Hts* St.: Ward)

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

FULL NAME *Refus O Wallace*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *Sept 22 1873*
(Month) (Day) (Year)

7 AGE *41* yrs. mos. ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Miner*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Lead & Zinc*

9 BIRTHPLACE (City or town, State or foreign country) *Galena Mo*

PARENTS
 10 NAME OF FATHER *Joseph Wallace*
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Scotland*
 12 MAIDEN NAME OF MOTHER *No Record*
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *No Record*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Mrs. Wallace wife*
 (Address) *R-5 Joplin Mo Hts*

15 Filed *Jan 1915* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 4 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Dec 4 1915* to *Jan 3 1915*, that I last saw him alive on *Jan 3 1915*, and that death occurred, on the date stated above, at *10 a.m.*

The CAUSE OF DEATH* was as follows:
Pul Tuberculosis
23A
 (Duration) *28* yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
A. A. Winchester M. D.
Jan 5 1915 (Address) *614 Main*

*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 *Wt Hope* DATE OF BURIAL *Jan 6 1915*

20 UNDERTAKER *Hurlbut Co* ADDRESS *Joplin Mo*

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) *Colton 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

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

County Jasper Registration District No. 411 File No. _____
 Township _____ or Village _____ or City Joplin NO. _____ St. _____ Ward _____
 Primary Registration District No. 2002 Registered No. 564

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

FULL NAME Rufus A. Wallace

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (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 Jan 5 - 1915 Dr. [Signature]
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h_____ alive on _____, 191____,
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows: _____

 (Duration) _____ mos. _____ ds.

Contributory _____
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____ 191____ (Address) _____

*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 RESIDENCES)

At place of death _____ yrs. _____ mos. _____ ds. 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 _____ 191____

UNDERTAKER _____ ADDRESS _____

Original file, date Jan 10 1915 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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1405

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