

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

3448

PLACE OF DEATH
County Shannon
Township Pike Creek
or
Village Hammond
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 823 File No. _____
Primary Registration District No. 6075 Registered No. 1

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

FULL NAME Jasper Meyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 6, 1915
(Month) (Day) (Year)

DATE OF BIRTH April 1, 1847
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h _____ alive on _____, 191____,

AGE 68 yrs. 9 mos. 6 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

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

Revolver wounds.
one shot passing through the vertebral column.
173 (Duration) ____ yrs. ____ mos. ____ ds.

BIRTHPLACE (City or town, State or foreign country) Carter Co Mo

Contributory, Dead suddenly.
(Duration) ____ yrs. ____ mos. ____ ds.

PARENTS
NAME OF FATHER unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
MAIDEN NAME OF MOTHER unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

(Signed) O. L. Petherick M. D.
Jan 6, 1915 (Address) Thianna

*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) W. H. Henderson
(ADDRESS) Thianna

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 _____

Filed Jan 8, 1915, _____ REGISTRAR

PLACE OF BURIAL OR REMOVAL Marcell Chapel DATE OF BURIAL Jan 8, 1915
UNDERTAKER Har. Morse ADDRESS Thianna

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, 8 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

County Shannon Registration District No. 823 File No. _____
Township Pike Creek or _____
Village _____ Primary Registration District No. 6075 Registered No. 1
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Jasper Meyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan. 6, 1915
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date _____, 191____, at _____.

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

The CAUSE OF DEATH* was as follows: a Homocidal Revolver wound on shot passing through the vertebral column

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

Contributory Dr. Kelly
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) P. L. Routh M. D.
1-6 1915 (Address) Shannon Mo.

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) _____

*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) _____

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 _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Wesley Chapel DATE OF BURIAL Jan 7 1915
UNDERTAKER not ours ADDRESS Wesley Chapel

File # Jan 8 1915 affidavit REGISTRAR _____

SUPPLEMENTARY Satisfactory Information Supplied.

N. B.—Every item of information should be carefully supplied. A fee 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.

Original file, date...

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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