

1 PLACE OF DEATH

County *Monroe*Township *Jackson*

Village

City

Registration District No. *5-8-2*Primary Registration District No. *5779*

File No.

Registered No. *43*

(NO. St. Ward)

18635

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

2 FULL NAME *Raymond Wells*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6 DATE OF BIRTH *Mar 25, 1916*
(Month) (Day) (Year)7 AGE *2 yrs 2 mos 3 ds*
If LESS than 1 day, hrs. or min.?8 OCCUPATION
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE
(City or town, State or foreign country) *Monroe Co*10 NAME OF FATHER *Alvin Wells*11 BIRTHPLACE OF FATHER
(City or town, State or foreign country) *Monroe Co*12 MAIDEN NAME OF MOTHER *Fannie May James*13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country) *Monroe Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clyde Tawney*(Address) *Paris Mo*15 Filed *5/31, 1916* *HCPayne*
RegistrarMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 31, 1916*
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Apr 1, 1916* to *May 31, 1916*,
that I last saw him alive on *May 30, 1916*,
and that death occurred, on the date stated above, at *3 a* m.

The CAUSE OF DEATH* was as follows:

*Gastritis 104*118C (Duration) *2* yrs. *2* mos. *15* ds.

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

(Signed) *M. C. Mc Murry* M. D.
May 31, 1916 (Address) *Paris, Mo*

*State the Disease Causing Death, or, in death 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 *Holiday* DATE OF BURIAL *June 1, 1916*20 UNDERTAKER *Jas W Speed* ADDRESS *Paris 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, 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 septichaemia," "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

Do not use this space.

~~12835~~
1916

26 1929

1. PLACE OF DEATH

County Marion
Township Marion
City Paris (No. 1)

Registration District No. 578
Primary Registration District No. 4340

File No. _____
Registered No. _____
St. _____ (Ward) _____

2. FULL NAME

Raymond B. Mills

(a) Residence No. _____ St. _____ Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

2

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

1/10/1916

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, _____ hrs. or _____ min.

2

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Marion Mo

10. NAME OF FATHER

Alvin Mills

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Marion Mo

12. MAIDEN NAME OF MOTHER

Daniel M. James

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Marion Mo

14. INFORMANT (Address)

Alvin Mills
Paris Mo

15. FILED

Apr 23 1929

Jugan Cannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1916

17. I HEREBY CERTIFY, That I attended deceased from _____, 1916, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ da.
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) M. C. McMurtry, M. D.
, 19____ (Address) Paris Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

Speedy Jan - Paris Mo

PHYSICIAN'S (check space) that it may be properly classified; that it may be properly classified; that it may be properly classified;

PARENTS

18435