

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

PLACE OF DEATH
County Lewis
Township or Village or City Bonhomme

Registration District No. 780 File No. 2697
Primary Registration District No. 6031 Registered No. 15
(NO. _____) (St. _____) (Ward _____)

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

FULL NAME Jake Westfall

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Don't know, 1 _____ (Month) (Day) (Year)

AGE about 80 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE St Charles Co Mo
City or town, State or foreign country

NAME OF FATHER Don't know the name

BIRTHPLACE OF FATHER Don't know
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER Don't know
(City or town, State or foreign country)

IF ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature Tony Westfall
(ADDRESS) Chesterfield

1/25 1918
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 9, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 26, 1917, to Jan 8, 1918, that I last saw him alive on Jan 8, 1918, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung
(Duration) 1 yrs. _____ mos. _____ ds.

Contributory Accident by fall
(SECONDARY) (Duration) _____ yrs. 6 mos. _____ ds.

(Signed) Robert Turry Jr M. D.
1/10, 1918 (Address) Chesterfield Mo

*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 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 _____

PLACE OF BURIAL OR REMOVAL Home lot DATE OF BURIAL 1-10, 1918

UNDERTAKER None ADDRESS _____

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.)

Registration District No. File No.

Primary Registration District No. Registered No.

If death occurred in
 hospital or institution
 give its NAME inside
 of street and number

St. Ward] ..
 ..

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE 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) ..

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 .., 191.., .. REGISTRAR ..

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH .., 191.. (Month) .., 191.. (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 ..
 The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY) .. yrs. mos.
 (Duration) .. yrs. mos.
 (Signed) .. M.
 .., 191.. (Address) ..

* State the Disease Causing Death, or, in deaths from Violent Causes, s
 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
 RECENT RESIDENTS)
 At place of death .. yrs. mos. ds. State .. yrs. mos.
 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 ..

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *St. Louis*
 Township *Bonhomme*
 or
 Village
 or
 City

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

Registration District No. *785* File No.
 Primary Registration District No. *6031* Registered No. *15*
 (NO. St. Ward)

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

2 FULL NAME

Jake West Jace

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
 (Month) (Day) (Year)

7 AGE
 If LESS than 1 day, hrs. or min.?

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

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

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)

15 Filed *3/7* 191*8*
St. A. Hummer
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jaw 9 191*8*
 (Month) (Day) (Year)

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

Duration) yrs. mos. da.
 CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. da.
 (Signed) M. D.
 191 (Address)

*State the Disease Causing Death, as 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 DATE OF BURIAL
 191

20 UNDERTAKER ADDRESS

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);

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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), *29ds.*; *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.)