

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

PLACE OF DEATH

County Meriton
 Township Franklin
 or Village Farmers
 or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 608 File No. 9929
 Primary Registration District No. 2807-A Registered No. 6

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

FULL NAME

James J. Smoot

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>↓</u>
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DATE OF BIRTH Nov 16, 1842
 (Month) (Day) (Year)

AGE 76 yrs. 4 mos. 5 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) Miller

BIRTHPLACE (City or town, State or foreign country) Lark Os Ohio

PARENTS	NAME OF FATHER <u>Nathan Smoot</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Os</u>
	MAIDEN NAME OF MOTHER <u>0</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>0</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Jeannie Russell
 (ADDRESS) Farmers Mo.

Filed March 11, 1918, L N Parnell
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 10, 1918
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Left, 1917, to March 10~~th~~, 1918, that I last saw him alive on March 10~~th~~, 1918, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Bone
27 A
27 A 28
28

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory Pulmonary T.B.
 (SECONDARY) (Duration) _____ yrs. 4 mos. _____ ds.

(Signed) J. S. Russell M. D.
March 11, 1918 (Address) Farmers 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 <u>Rocky export, Mo</u>	DATE OF BURIAL <u>Mar 11</u> , 191 <u>8</u>
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UNDERTAKER <u>White & Pague</u>	ADDRESS <u>Farmers Mo</u>
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PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write the word*)

DATE OF BIRTH _____

AGE _____ (Month) _____ (Day) _____ (Year)

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
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____

(Day) _____, 191____

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) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

_____ (Address)

M. D. _____

*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 _____ 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

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

PLACE OF DEATH Newton
County Franklin
Township Franklin
or Village Fairview
or City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 608 File No. _____
Primary Registration District No. 5807-A Registered No. 6

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

FULL NAME James J. Smart

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 10, 1918
(Month) (Day) (Year)

DATE OF BIRTH September 16, 1842
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 11, 1918, to Mar 10, 1918, that I last saw him alive on March 10, 1918, and that death occurred, on the date stated above, at 1:30 P m.

AGE 76 yrs. 5 ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the Bone
(Duration) 2 yrs. _____ mos. _____ ds.

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

Contributory Pulmonary T. B.
(Duration) 10 yrs. _____ mos. _____ ds.
(Signed) S. A. Russell M. D.
Mar 11, 1918 (Address) Fairview Mo

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

NAME OF FATHER Nathan Smart

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio

MAIDEN NAME OF MOTHER Unk.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unk.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory information Susan

*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 _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL March 11, 1918

Filed March 11, 1918. L. H. Parnell REGISTRAR

UNDERTAKER White & Pogue ADDRESS Fairview, 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*, *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 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.)