

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

Do not use this space.

426

1. PLACE OF BIRTH

County Butler  
Township Expps  
City (No. ....) .....

Registration District No. 980  
Primary Registration District No. 5-132

File No. ....  
Registered No. ....  
St. .... Ward

2. FULL NAME

James Monroe Williams  
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1, 1897  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
77 7 21

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

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

10. NAME OF FATHER Henry Williams  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Not Known  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known  
(STATE OR COUNTRY)

14. INFORMANT H. E. Williams  
(Address) Ill.

15. FILED 1/19, 1929 M. B. Stoddumall  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 29

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to Jan 10, 1929, that I last saw him alive on Jan 10, 1929, and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Broncho-Pneumonia

CONTRIBUTORY (SECONDARY) .....

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) W. S. Bailey, M. D.  
1-17, 1929 (Address) Poplar Bluff 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn DATE OF BURIAL 1-17-1929

20. UNDERTAKER Frankundi Co Poplar Bluff ADDRESS

N. B.—Every item CAUSE OF DEATH

1929  
12  
0  
0  
6-9-18  
213  
31

RECEIVED  
EXACTLY. PHYSICIAN  
AGENT 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, 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); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (same origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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 "Asthénia," "Anémia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Butler Registration District No. 980 File No. \_\_\_\_\_  
 Township Epps Primary Registration District No. 5122 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Monroe Williams  
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M.</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6 4 1859</u>				
7. AGE	YEARS <u>97</u>	MONTHS <u>7</u>	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work _____				
(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) _____				
10. NAME OF FATHER _____				
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____				
12. MAIDEN NAME OF MOTHER _____				
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 7 1929 19

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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.

14. INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_

15. FILED 3/90 1929 M. S. Caldwell  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK--THIS IS PERMANENT RECORD

CAUSE OF DEATH of information should be fully supplied. AGE should be properly ascertained. OCCUPATION if any should state in plain terms, so that REGISTRARS SHALL be properly classified. FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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