

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

PLACE OF DEATH
County Leaslip
Township Blackwater
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 217 File No. 672
Primary Registration District No. 3297 Registered No. _____

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

FULL NAME Joe Amick Manning

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Oct 15, 1866

AGE 50 yrs. 2 mos. 27 ds.

IF LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

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

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

BIRTHPLACE

(City or town, State or foreign country) Moniteau Co. Mo.

PARENTS

NAME OF FATHER James H. Manning

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

MAIDEN NAME OF MOTHER E. Per. W.

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Moniteau Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida B. Manning

(ADDRESS) Nelson Mo.

Filed 1/14, 1917, J. V. [Signature]

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14, 1917

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 7, 1917, to Jan 12, 1917, that I last saw him alive on Jan 12, 1917, and that death occurred, on the date stated above, at 3:30 pm.

The CAUSE OF DEATH* was as follows:

Compensatory pneumonia
10
13

(Duration) ___ yrs. ___ mos. 10 ds.

Contributory Nephritis
(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Lee J. Throck

M. D.

Jan 14, 1917 (Address) Nelson 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

DATE OF BURIAL

California Mo Jan 18, 1917

UNDERTAKER

ADDRESS

L. M. Throck Nelson 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, 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, 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 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Cooper
 Township Blackwater
 or
 Village
 or
 City

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

Registration District No. 217

File No.

Primary Registration District No. 5297

Registered No.

(NO

St.:

Ward)

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

2 FULL NAME

Jim Smith Manning

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH

Jan 12 1917
 (Month) (Day) (Year)

6 DATE OF BIRTH

(Month) (Day) (Year)

7 AGE

If LESS than
 1 day.....hrs.
 or.....min.?

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..... m.

The CAUSE OF DEATH* was as follows:

Croupus Pneumonia

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)

CONTRIBUTORY

(Secondary)

(Signed)

Jan 15 1917 (Address) Helson

*State the Disease Causing Death, or, 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

20 UNDERTAKER

ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 1/4 1917

Registrar

Original file, date

JAN

1917

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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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 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.)