

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

PLACE OF DEATH

County Knox
Township Shelby
or
Village Berry
or
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 439
Primary Registration District No. 4257

File No. 31795
Registered No. 9

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

FULL NAME Sarah M. Dwyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single
DATE OF BIRTH Sept 5, 1901
(Month) (Day) (Year)
AGE 10 yrs. 6 mos. 0 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) _____

DATE OF DEATH Sept 4, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 4, 1911, to Sept 2, 1911, that I last saw her alive on Sept 2, 1911, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
93A

BIRTHPLACE (City or town, State or foreign country) Neokuk, Ga

(Duration) 1 yrs. 2 mos. _____ ds.

NAME OF FATHER Thomas Dwyer

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

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

(Signed) M. E. Leman M. D.
Sept 4, 1911 (Address) Berry, Mo

MAIDEN NAME OF MOTHER Sarah Reely

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Knox County

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Bessie Riley

Where was disease contracted If not at place of death? _____

Former or usual residence. _____

(ADDRESS) Berry, Mo

PLACE OF BURIAL OR REMOVAL St. Marys cemetery DATE OF BURIAL Sept 5, 1911

Filed Sept 4, 1911 M. E. Leman REGISTRAR

UNDERTAKER Kriegshauser Bros ADDRESS Edina, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. No. 2. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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*, *Sar-*

coma, 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.)



County Mos. Registration District No. 439 File No. _____
 Township _____ or Village Barney Primary Registration District No. 4257 Registered No. 9
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Frank M. Boyer (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 5 1901
 (Month) (Day) (Year)

AGE 10 yrs 6 mos. 6 ds.
 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
 (City or town, State or foreign country) North St. Louis

PARENTS

NAME OF FATHER Thomas M. Boyer
 BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis
 MAIDEN NAME OF MOTHER Mary Kelly
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) St. Mary Co Mo

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9-4 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to 9-2, 1911, that I last saw him alive on 9-2, 1911, and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:
Organic Heart disease
Aortic Insufficiency

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

Contributory (Second) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. E. Luman M. D.
 1911 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mary Kelly
 (ADDRESS) Barney Mo.
 Filed Sept 10 1911 J. E. Luman REGISTRAR

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? _____
 Form of or usual residence _____

PLACE OF BURIAL OR REMOVAL St. Marys Cem. DATE OF BURIAL 9-5 1911
 UNDERTAKER Amphersuch Bros. Thera. Mo. ADDRESS _____

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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