

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

PLACE OF DEATH

County Pemscot
Township Hoyti
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registr. District No. 653 File No. 32213
Primary Registration District No. 5864 Registered No. 83

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

FULL NAME Sarah Boyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF DEATH Sept. 26, 1911
(Month) (Day) (Year)

DATE OF BIRTH Nov. 16, 1850
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 25, 1911, to Sept 26, 1911, that I last saw her alive on Sept 25, 1911, and that death occurred, on the date stated above, at 3 A. m.

AGE 61 yrs. 6 mos. 10 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Coagulative Chills
38 189
(Duration) ___ yrs. ___ mos. 1 ds.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE (City or town, State or foreign country) Marion Ky.

PARENTS
NAME OF FATHER William Symptom
BIRTHPLACE OF FATHER (City or town, State or foreign country) Marion, Ky.
MAIDEN NAME OF MOTHER Sallie Dilback
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marion, Ky.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) F. S. Boyer M. D.
Sept. 26, 1911 (Address) Hoyti, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Symptom
(ADDRESS) Hoyti, 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 _____

Filed Sept 26 1911 J. W. Johnson REGISTRAR

PLACE OF BURIAL OR REMOVAL Gr. Boyer DATE OF BURIAL Sept 27, 1911
UNDERTAKER G. W. Davis ADDRESS Hoyti, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement 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, 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 septicæmia," "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.)

HUGH STEPHENS, JEFFERSON CITY.



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
 County Plumas
 Township Hayti
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 653 File No. _____
 Primary Registration District No. 3864 Registered No. 83
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Sarah Bayer

PERSONAL AND STATISTICAL PARTICULARS

(SEX) M COLOR OR RACE W SINGLE Widow
 MARRIED _____
 WIDOWED _____
 OR DIVORCED _____
 (Write the word)
 DATE OF BIRTH 3/16, 1880
 (Month) (Day) (Year)
 AGE 61 yrs. 6 mos. 10 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) Marion Ky.
 NAME OF FATHER John G. Gage
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Marion Ky.
 MAIDEN NAME OF MOTHER Esther DeBar
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marion Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Thomas Gage
 (ADDRESS) Hayti Mo
 Filed Sept. 28, 1911
 REGISTRAR J. W. Johnson

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9/26, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from 9-25, 1911, to 9-26, 1911,
 that I last saw h.w. alive on 9-25, 1911,
 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral chill, followed by
Coma until death.

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. A. Mays M. D.
9-26, 1911 (Address) Hayti 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 Dry Bayou
 DATE OF BURIAL 9-27, 1911
 UNDERTAKER G. W. Davis
 ADDRESS Hayti, Mo

Original file, date 9-26, 1911. 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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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.)

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