

1 PLACE OF DEATH

County

St Francis

Township

or

Village

or

City

Registration District No.

774

File No.

N 89947

Primary Registration District No.

4465

Registered No.

(NO

St.

Ward)

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

2 FULL NAME

Terwood F Winer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE
MARRIED
WIDOWED
ORphaned
(Write the word)

Single

6 DATE OF BIRTH

Sept 2

(Month)

914

(Day)

(Year)

7 AGE

3

17

yrs.

mos.

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

8 OCCUPATION

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

Child

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

9 BIRTHPLACE

(City or town, State or foreign country)

Flat River mo.

10 NAME OF FATHER

R F Winer

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

Jefferson Co.

12 MAIDEN NAME OF MOTHER

Mammie McMullin

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

Jefferson Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A F Winer

(Address)

Flat River mo

15

Filed

Dec 19, 1914

A F Winer

Registrar

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

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH

Dec 18

(Month)

(Day)

1914

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Dec 18, 1914, to Dec 18, 1914.

that I last saw him alive on

I have seen him alive

191

and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Smothered - Suffocated
1874

Bed Cloths

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

CONTRIBUTORY
(Secondary)

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

(Signed)

J L Keist

M. D.

Dec 19, 1914 (Address) Flat River

*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

Swarbrick Cemetery

DATE OF BURIAL

Dec 20, 1914

20 UNDERTAKER

H. P. Winer

ADDRESS

Flat River 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, 8 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.)

PLACE OF DEATH

County

*St. Francis*REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Township

Registration District No.

File No.

or

Village

Primary Registration District No.

Registered No.

or

City

(No.

St.

Ward)

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

FULL NAME

Erwood J. Miner

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

*M**W**S*

(Month)

(Day)

191*4*
(Year)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

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

yrs. mos. ds.

HEREBY CERTIFY, that I attended deceased from
of infarctory infirmities (as supplied), 191*4*,
that I last saw him alive on _____, 191*4*,
and that death occurred, on the date stated above, at *9:10* m.

The CAUSE OF DEATH* was as follows:

myocardial infarction

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)

(Duration)

yrs.

mos.

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

PARENTS

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)

(Signed)

*Dr. Tapping*191*4* (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
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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filed

12/19 191*4**Dr. Tapping*
REGISTRAR

UNDERTAKER

ADDRESS

Original file, date

DEC

1914

19

All information called for must be written on this Supplementary Certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state OCCUPATION in very important cases.

SATISFACTORY INFORMATION SUPPLIED.
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Revised United States Standard Certificate of Death

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

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