

ALL PHYSICIANS SIGNING THIS OCCUPATION IS VERY IMPORTANT.

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

PLACE OF DEATH

County Texas
Township Boone
or
Village
or
City (NO. _____ St. _____ Ward)

Registration District No. 868 File No. 18076
Primary Registration District No. 6150 Registered No. 105

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

FULL NAME Philip P Canoy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

DATE OF DEATH May 25, 1915
(Month) (Day) (Year)

DATE OF BIRTH Nov 20, 1877
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

AGE 81 yrs. 5 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?

that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 5 P.m.

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) on the farm

The CAUSE OF DEATH* was as follows:
Unknown Cause Died Suddenly
Complaining of Colic
in left side (see over dead)

BIRTHPLACE (City or town, State or foreign country) North Carolina

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

NAME OF FATHER David Canoy

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

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

(Signed) No Physician M. D. May 31, 1915 (Address) _____

MAIDEN NAME OF MOTHER Don't know

*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) Don't know

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

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

(Informant) J. R. Buckner
(ADDRESS) Minierpost Mo

Former or usual residence _____

Filed May 26, 1915 W. R. Reid REGISTRAR

PLACE OF BURIAL OR REMOVAL Smith Cem Phelps Co DATE OF BURIAL May 26, 1915
UNDERTAKER Cameron T Co ADDRESS Picking 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, peritoneum*, 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.)

Every item of information should be carefully suppressed. Above amount be inserted next to it. EXACTLY. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of cause of OCCUPATION is very important.

1 PLACE OF BIRTH

County Texas
 Township Boone
 or
 Village
 or
 City

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

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

Registration District No. 868 File No.
 Primary Registration District No. 6150 Registered No. 15

(NO. St. Ward)

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

2 FULL NAME Philip P. Canoy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH May 25 1915
 (Month) (Day) (Year)

6 DATE OF BIRTH
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
 191 to 191

7 AGE
 If LESS than 1 day, hrs. or min.?

that I last saw him alive on 191 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

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)

(Duration) yrs. mos. ds.

10 NAME OF FATHER

CONTRIBUTORY (Secondary)

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

(Duration) yrs. mos. ds.

12 MAIDEN NAME OF MOTHER

(Signed) J. R. Buchner
May 26 1915 (Address) Kinder post 210

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

(Informant)
 (Address)

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

15 Filed May 26 1915 H. R. [Signature] Registrar

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 191

20 UNDERTAKER ADDRESS

Original file, date May 1915

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

Satisfactory Information Supplied. SUPPLEMENTARY CERTIFICATE. Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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