

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

PLACE OF DEATH  
County Washington  
Township Belleve Registration District No. 885 File No. \_\_\_\_\_  
or \_\_\_\_\_ Primary Registration District No. 536 Registered No. 43728  
Village \_\_\_\_\_ or \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

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

FULL NAME James W. Reynolds

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH December 8, 1914  
(Month) (Day) (Year)

DATE OF BIRTH March 10, 1849  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from November 29 1914, to Dec 8, 1914, that I last saw him alive on Dec 8, 1914, and that death occurred, on the date stated above, at 1135 B

AGE 47 yrs. 8 mos. 28 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Brain Infection

OCCUPATION (a) Trade, profession, or particular kind of work Farmer 514  
(b) General nature of industry, business, or establishment in which employed (or employer) 129

BIRTHPLACE (City or town, State or foreign country) Benjin

(Duration) \_\_\_ yrs. 11 mos. 14 ds.  
Contributory Myelitis  
(SECONDARY) (Duration) \_\_\_ yrs. 10 mos. 11 ds.

NAME OF FATHER Unknown

(Signed) W. W. Reynolds M.D.  
1914 (Address) Benjin

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

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

MAIDEN NAME OF MOTHER Unknown

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

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

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) W. W. Reynolds  
(ADDRESS) Benjin Mo

Former or usual residence \_\_\_\_\_

FILE NO. 12-101 1914 W. H. Hensel REGISTRAR

PLACE OF BURIAL OR REMOVAL Grider Cemetery DATE OF BURIAL Dec 10 1914

UNDERTAKER C. J. Hill ADDRESS Benjin Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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*, *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 ..... 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

PLACE OF DEATH *Washington*  
 County *Washington* REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW  
 Township ..... Registration District No. *885* CERTIFICATE OF DEATH  
 or ..... File No. *43728*  
 Village ..... Primary Registration District No. *6177* 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 *James W. Reynolds*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *M*  
 6 DATE OF BIRTH *March 10 1849*  
 (Month) (Day) (Year)  
 7 AGE *67 yrs 8 mos 28 ds* If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS  
 10 NAME OF FATHER  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country)  
 12 MAIDEN NAME OF MOTHER?  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

15 Filed *17/10 1916* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *8 6*  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191 that I last saw h. alive on 191 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:  
*prolonged use of catheter through pro enlarged and I think numerous prostate gland*  
 (Duration) yrs mos ds. *4*

CONTRIBUTORY (Secondary) *Cystitis*  
 (Signed) *W H Reynolds* M. D.  
*2/25, 1917* (Address) *Blissman*

\*State the Disease Causing Death, or, in death 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 191

20 UNDERTAKER ADDRESS

SUPPLEMENTARY CERTIFICATE  
 REGISTERED  
 JAMES W. REYNOLDS

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