

22034

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

PLACE OF DEATH
County Monroe
Township Portage
or
Village
or
City

Registration District No. 607 File No. 23
Primary Registration District No. 5806 Registered No.

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

FULL NAME Case Edward Boyd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE w. SINGLE single MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH 7-14-23
(Month) (Day) (Year)

DATE OF BIRTH Jan 26 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 7-12-23 to 7-14-23 that I last saw him alive on 7-12-23

AGE 5 yrs. 15 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 5:00 m. The CAUSE OF DEATH* was as follows:

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

119B
130
118 Congestion of Stomach
(Duration) yrs. mos. ds.

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

PARENTS NAME OF FATHER A E Boyd BIRTHPLACE OF FATHER (City or town, State or foreign country) Portageville MAIDEN NAME OF MOTHER Hattie E. Hand BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) H. C. ... M. D. 7-14-23 (Address) Portageville

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A E Boyd (ADDRESS) Portageville MO,

*State the Disease Causing Death, or, in deaths from Violent Causes, state 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 10/1 1923 R. K. Miller REGISTRAR

PLACE OF BURIAL OR REMOVAL Portageville Cemetery DATE OF BURIAL 7-14-23 UNDERTAKEER R. D. Young ADDRESS Portageville Mo,

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

PLACE OF DEATH

County _____
 Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 or City _____ (NO. _____ St. _____ Ward) _____
 ([f death occurred in a hospital or institution, give its NAME instead of street and number])

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH	(Month) _____, (Day) _____, (Year) _____	
AGE	_____ yrs., _____ mos., _____ 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) _____

BIRTHPLACE OF FATHER (City or town, State or foreign country)	NAME OF FATHER
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	MAIDEN NAME OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (ADDRESS) _____

Filed _____, 191____, REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____, (Month) _____, (Day) _____, (Year) _____

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

The CAUSE OF DEATH^y was as follows:

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

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

(Signed) _____, 191____ (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. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

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

1. PLACE OF DEATH

County New Madrid Registration District No. 607 File No.
 Township Portage Primary Registration District No. 5806 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Carl Edward Boyd
 (a) Residence, No. St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED s (specify the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 10/1 1923 R. K. Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 14 19 23

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h. give or 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

congestion of stomach and bowels
Neptic

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, DATE OF
 DID AN OPERATION PRECEDE DEATH?
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY. K

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

PARENTS

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, 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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate, will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN