

WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
County Marion
Township Liberty
or
Village
or
City Palmyra (NO. _____) St. _____ Ward _____

Registration District No. 5-48 File No. 31254
Primary Registration District No. 4325 Registered No. 5-

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

FULL NAME James St Clair

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Sept 15, 1890
(Month) (Day) (Year)

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

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

BIRTHPLACE (City or town, State or foreign country) Hancock Co Mo

NAME OF FATHER George St Clair

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

MAIDEN NAME OF MOTHER Flourance Chifford

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Hancock Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Samuel Elder

(ADDRESS) Palmyra Mo

Filed Oct. 17, 1910 J. S. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 16th, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 13th, 1910, to Oct 15th, 1910, that I last saw him alive on Oct 15th, 1910, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows: Appendicitis
121A

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

Contributory Abscess Base
(SECONDARY) burst

(Signed) J. E. Ruckenberg M. D.
1910 (Address)

*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 Palmyra Mo DATE OF BURIAL Oct 17, 1910

UNDERTAKER W. T. Tuley ADDRESS Palmyra 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

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*

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PLACE OF DEATH

County.....
 Township..... Registration District No.....
 or.....
 Village..... Primary Registration District No.....
 or.....
 City..... (NO.....)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF BIRTH (Month)..... (Day)..... (Year).....	DATE OF DEATH I..... that I last e..... and that d.....
AGE	IF LESS than 1 day.....hrs. or.....min.?yrs.....mos.....ds.			

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).....

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

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

(ADDRESS).....

Filed..... 191..... REGISTRAR

Contrib (Signed).....

*State (b) LENGTH OF RECENT RES At place of death Where was if not atpl Former or usual resid PLACE OF UNDERTAK

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