

WRITE 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 Pettis
Township _____ or Village _____ or City Sedalia (NO. _____) St. _____ Ward _____
Registration District No. 668 File No. 35171
Primary Registration District No. 2032 Registered No. 232
FULL NAME Charles A. Boyle
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX White COLOR OR RACE male SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH Oct 19, 1863
(Month) (Day) (Year)

AGE 47 yrs. - mos. - ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Railroad Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) R. Ry.

BIRTHPLACE
(City or town, State or foreign country) Greenburg, Pa.

PARENTS
NAME OF FATHER Daniel Boyle
BIRTHPLACE OF FATHER (City or town, State or foreign country) Jersey City N.J.
MAIDEN NAME OF MOTHER Sarah M. Gough
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Camden Co Pa.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chas Boyle
(ADDRESS) Sedalia Mo

Filed Nov. 9 1910 Saw Kelly
REGISTRAR Wesley

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 8, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1910, to Nov 8, 1910, that I last saw him alive on Nov 8, 1910, and that death occurred, on the date stated above, at _____ m.

CAUSE OF DEATH* was as follows:
Tuber culos Laryngitis

Contributory (SECONDARY) Consume Moped
Duration) yrs. mos. ds. 27

(Signature) J. M. Harris M. D.
Duration) yrs. mos. ds. 27
(Address) 116 N. Main St Sedalia Mo.

* 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 Sedalia Mo DATE OF BURIAL Nov 11, 1910
UNDERTAKER McLaughlin Bros ADDRESS Sedalia, 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 house, should be taken to report specifically the occupation of persons engaged in domestic service for wages, as *House-keeper, Cook, Housemaid*, etc. If the occupation has 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 by "Retired, 8 yrs.". For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, of DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the accepted term for the same disease. Examples: *Scarlet fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Cerebrospinal meningitis," unqualified, is indefinite); *Tuberculosis of meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. (name origin; "Cancer" is less definite; 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.)

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