

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 St. Louis
Township Cass
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 648

File No. 4824

Primary Registration District No. 6111

Registered No. 1

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

FULL NAME William Henry Boyer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb 29, 1851
(Month) (Day) (Year)

AGE 59 yrs 10 mos 8 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Mechanics

(b) General nature of industry, business, or establishment in which employed (or employer) 5-07

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

NAME OF FATHER Abraham Boyer

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

MAIDEN NAME OF MOTHER Mary Harrison

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Boyer

(ADDRESS) Jamesville Mo

Filed Jan 7 1911 J. E. Cox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 6, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 31, 1910, to Jan 6, 1911, that I last saw him alive on Jan 6, 1911, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

La Grippe followed by Pneumonia.
IIA

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory
(SECONDARY)

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

(Signed) J. H. Wade M. D.
(Address) Powers de Leon 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 10 yrs. _____ mos. _____ ds. In the State 39 yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence Oklahoma

PLACE OF BURIAL OR REMOVAL Dry Valley Cemetery DATE OF BURIAL Jan 8, 1911

UNDERTAKER none ADDRESS _____

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

(NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

(If 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)
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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

(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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

_____ (Month) _____ (Day) _____ (Year)

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: _____

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

Contributory

(SECONDARY)

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

(Signed) _____

(Address) _____

_____, 191 _____ 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

191 _____

PLACE OF DEATH

County Stone
 Township Cass
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RE-
 CEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW.

Registration District No. 648
 Primary Registration District No. 6111

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

File No. 4824
 Registered No. 61

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

FULL NAME William Wesley Boyer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Feb. 28 - 1854</u> (Month) (Day) (Year)		
AGE <u>59</u> yrs. <u>10</u> mos. <u>8</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>mechanics</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>		
PARENTS	NAME OF FATHER <u>Abraham Boyer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Mary Harmon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 6 - 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from
Dec - 31, 1910, to Jan - 6th, 1911,
 that I last saw him alive on Jan - 6th, 1911,
 and that death occurred, on the date stated above, at 3:49 m.
 The CAUSE OF DEATH* was as follows:
Maligntant followed by Pneumonia
 (Duration) _____ yrs. _____ mos. 8 ds.

Contributory
 (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. H. Wade M. D.
Jan 6 1911 (Address) Ponca de La Poudre, 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 10 yrs. _____ mos. _____ ds. In the State 19 yrs. _____ mos. _____ ds.
 Where was disease contracted
 If not at place of death?
 Former or usual residence Oklahoma

PLACE OF BURIAL OR REMOVAL <u>Dry Valley Cemetery</u>	DATE OF BURIAL <u>Jan - 8</u> , 19 <u>11</u>
UNDERTAKER <u>Can not give name</u>	ADDRESS <u>X</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Boyer
 (ADDRESS) Jamestown, Mo.

Filed Jan 7 1911 Ira E. Cox
 REGISTRAR

JAN

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

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*, *Sar-*

coma, 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 septichaemia," "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.)