

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.

PLACE OF DEATH

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

County Perry
Township St. Marys
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 663 File No. 25547
Primary Registration District No. 3881 Registered No. 13

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

FULL NAME Acey Holmes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If fits the word) _____

DATE OF BIRTH Oct 10, 1911
(Month) (Day) (Year)

AGE 1 yrs. 9 mos. 4 ds. if LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Perry co. mo

PARENTS
NAME OF FATHER David Holmes
BIRTHPLACE OF FATHER (City or town, State or foreign country) Perry co. mo.
MAIDEN NAME OF MOTHER Mary Butcher
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Madison co. mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gid Guter
(ADDRESS) Missmith mo

Filed 7/7 1911 Geoff. Bloyloch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 8, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 7/6 P.M., 1911, to July 7/9 P.M., 1911, that I last saw him alive on July 7 9 P.M., 1911, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
acute poisoning of
baumatic concentrated dye
17 1/2 F
165 (Duration) ___ yrs. ___ mos. 1 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Geo. Bloyloch M. D.
July 8, 1911 (Address) Silver Lake 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 Anderson graveyard DATE OF BURIAL 7/7 1911
UNDERTAKER none ADDRESS _____

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 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Boyer
Township Smalye
Village
City (NO. _____ St. _____ Ward _____)

Registration District No. 663 File No. 25547
Primary Registration District No. 5881 Registered No. _____

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

FULL NAME Ray Holmes

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH _____	191____
DATE OF BIRTH _____			HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
AGE _____			that I last saw h_____ alive on _____, 191____,	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			and that death occurred, on the date stated above, at _____ m.	
BIRTHPLACE (City or town, State or foreign country) _____			The CAUSE OF DEATH* was as follows: <u>Poisoning, Eye</u> <u>Accidental</u>	
PARENTS NAME OF FATHER _____ BIRTHPLACE OF FATHER _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER _____			160 (Duration) _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Contributory _____	
(Informant) _____			(Signed) _____ M. D. _____	
(ADDRESS) _____			_____, 191____ (Address) _____	
Filed _____ 191____			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
REGISTRAR _____			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 _____	DATE OF BURIAL _____ 191____
			UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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