

MARGIN RESERVED FOR BINDING

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 W. Kalb.
Township Polk
or
Village Union Star
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 262 File No. 725
Primary Registration District No. 4161 Registered No. 1

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

FULL NAME George Moyes

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>male</u>	COLOR OR RACE <u>white</u>	MARRIAGE <u>married</u> MARRIED WIDOWED DIVORCED (Write the word)	DATE OF DEATH <u>Jan. 12, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Oct 1st, 1828</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>July 1, 1911</u> , to <u>Jan 12, 1912</u> , that I last saw him alive on <u>Jan 12th</u> , 1912, and that death occurred, on the date stated above, at <u>6^{1/2} a.m.</u>	
AGE <u>83</u> yrs. <u>3</u> mos. <u>12</u> ds.			The CAUSE OF DEATH* was as follows: <u>31 Gen. Debility due to</u> <u>old age</u> <u>162</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-522</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Glasgow Scotland</u>			Contributory <u>Inf. of bladder</u> (SECONDARY) <u>Inf. of kidney</u> (Duration) <u>2</u> yrs. <u>6</u> mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Henry Moyes</u>		(Signed) <u>Osceola L. Perkins</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Glasgow Scotland</u>		<u>1/19, 1912</u> (Address) <u>Union Star Mo</u>	
	MAIDEN NAME OF MOTHER <u>Mat. Know</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scotland</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. A. Moyes</u> (ADDRESS) <u>Union Star Mo</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>Jan. 13, 1912</u> <u>E. M. Reynolds</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Union Star Mo</u> DATE OF BURIAL <u>Jan 14, 1912</u>	
			UNDERTAKER <u>William Stanton</u> ADDRESS <u>Union Star Mo</u>	

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 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.)



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

PLACE OF DEATH
County DeKalb
Township Union Star
Village Union Star
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 202 File No. 725
Primary Registration District No. 4161 Registered No. 1

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

FULL NAME George Mayer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Oct 1 1828</u> <small>(Month) (Day) (Year)</small>		
AGE <u>83 yrs. 3 mos. 12 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Glasgow Scotland</u>		
PARENTS	NAME OF FATHER <u>Henry Mayer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Glasgow Scotland</u>	
	MAIDEN NAME OF MOTHER <u>none</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scotland</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 12 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1 1911, to Jan 12 1912, that I last saw him alive on Jan 12 1912 and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:
General Debility Due to Old age

(Duration) 8 yrs. 6 mos. ds.

Contributory Inf. Bladder = Interstitial Nephritis
(Duration) 2 yrs 6 mos. ds.

(Signed) Oscar L. Perkins M. D.
1/13/02 1912 (Address) Union Star 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 <u>Union Star Mo</u>	DATE OF BURIAL <u>Jan 14 1912</u>
UNDERTAKER <u>William Stanton</u>	ADDRESS <u>Union Star</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Mayer
(ADDRESS) Union Star Mo

Filed Jan 13 1912 E. M. Reynolds
REGISTRAR

JAIN + All information called for must be written on this Supplementary Certificate. No

Revised United States Standard Certificate of Death

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

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