

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

PLACE OF DEATH

County Holt  
Township Lincoln  
or  
Village Carrington  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 268 File No. 3 1019

Primary Registration District No. 4214 Registered No. 1

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

FULL NAME Francis W. Weyler

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE 5 yrs. 18 mos. 18 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) 0

BIRTHPLACE (City or town, State or foreign country) Carrington Mo.

NAME OF FATHER Walter Weyler

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

MAIDEN NAME OF MOTHER Mary Dahlman

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed Jan 31, 1912 J. N. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 28, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15, 1911, to Jan 28, 1912, that I last saw him alive on Jan 28, 1912, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Capillary Bronchitis) + catarrh of  
11913  
107 A (Duration) 4 yrs. 13 ds.

Contributory Enterocolitis  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) J. N. Long M. D.  
\_\_\_\_\_, IBI (Address) Carrington 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 RESIDENCE)

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 St. Joseph DATE OF BURIAL Jan 28, 1912

UNDERTAKER W. A. Schuler ADDRESS Carrington Mo.

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.

# 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, peritonaeum*, 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.)



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.

PLACE OF DEATH

County Holt  
 Township Cornieg  
 or  
 Village Cornieg  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Registration District No. 368 File No. 31019  
 Primary Registration District No. 421-4 Registered No. 1

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

FULL NAME Francis W. Kyler

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Aug 10 1911</u> <small>(Month) (Day) (Year)</small>		
AGE <u>5 yrs. 18 ds.</u>		If LESS than 1 day, ___ hrs or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Cornieg Mo.</u>		
PARENTS	NAME OF FATHER <u>Walter Kyler</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St. Louis Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Margaret Dahlen</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Karover Germany</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 28 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15 to Jan 28, 1912, that I last saw deceased on Jan 28, 1912, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia (Capillary Bronchitis) catarrhal

(Duration) \_\_\_ yrs. \_\_\_ mos. 13 ds.

Contributory intercostal  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 6 ds.

(Signed) L. H. Lang M. D.  
Jan 30 1912, (Address) Cornieg 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) F. W. S. Kyler  
 (ADDRESS) Cornieg Mo.  
 Filed Feb 2 1912 L. H. Lang REGISTRAR

PLACE OF BURIAL OR REMOVAL 114 Hope  
 DATE OF BURIAL Jan 30 1912  
 UNDERTAKER Wm. A. Schooler ADDRESS Cornieg Mo.

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

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Association]

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