

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 Maryland
Township Maryland
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 598 File No. 2078
Primary Registration District No. 5792B Registered No. 2

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

FULL NAME Allen Bryan

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)
DATE OF BIRTH <u>Aug 25, 1874</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>4</u> mos. <u>26</u> ds. 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) <u>Farming</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Keokuk</u>		
PARENTS	NAME OF FATHER <u>Mr. Bryan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Keokuk</u>	
	MAIDEN NAME OF MOTHER <u>Mary Astor</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Keokuk</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 21, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 17, 1912, to Jan 21, 1912, that I last saw him alive on Jan 21, 1912, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning
137 B
(Duration) yrs. mos. 6 ds.

Contributory
(SECONDARY) (Duration) yrs. mos. ds.
(Signed) G. H. Nelson M. D.
Jan 22, 1912 (Address) Keokuk

*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) M. J. Bryan
(ADDRESS) Keokuk

PLACE OF BURIAL OR REMOVAL
Hopewell, Iowa
DATE OF BURIAL
Jan 23, 1912
UNDERTAKER
W. A. Hedwell
ADDRESS
Versailles, Mo

Filed Jan 22, 1912 by A. H. Hultman
REGISTRAR

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

PLACE OF DEATH

County.....
 Township..... Registration District No..... File No.....
 or Village..... Primary Registration District No..... Registered No.....
 or City..... (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
(Write the word)

DATE OF BIRTH..... (Month)..... (Day)..... (Year).....
 I.....
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).....

PARENTS

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)..... 191.....

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

Contributory
 (SECONDARY)

(Signed)..... 191..... (Address)..... M. D.
 (Duration)..... yrs..... mos..... ds.

*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..... **DATE OF BURIAL**..... 191.....
UNDERTAKER..... **ADDRESS**.....

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

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

PLACE OF DEATH
County Morgan
Township Morgan
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 598 File No. 2078
Primary Registration District No. 5792B Registered No. 2

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

FULL NAME Allen Buzan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word)
DATE OF BIRTH <u>Aug 25, 1874</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>26</u> mos. <u>6</u> ds.		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>Waverly, Ky.</u>		
PARENTS	NAME OF FATHER <u>Wm. Buzan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Waverly, Ky.</u>	
	MAIDEN NAME OF MOTHER <u>Lucy Gibson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky.</u>	

DATE OF DEATH
Jan 21, 1912
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Jan 17, 1912, to Jan 21, 1912, that I last saw him alive on Jan 21, 1912, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory Don't know
(SECONDARY)

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

(Signed) E. S. Wilson M. D.
726 13, 1912 (Address) Fortuna

*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) Wm. J. Buzan
(ADDRESS) Waverly, Ky.
Filed Jan 25, 1912 H. N. Luttrell REGISTRAR

PLACE OF BURIAL OR REMOVAL Hopewell Cem DATE OF BURIAL Jan 23, 1912
UNDER-TAKER N. A. Kidwell ADDRESS Versailles, 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 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.)