

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 \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_

Registration District No. 391Primary Registration District No. 1003File No. 18320Registered No. 4123St. 13 Ward

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

FULL NAME Isaac Ray

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Colored</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>
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DATE OF BIRTH <u>Not known</u>	(Month) _____ (Day) _____ (Year) _____
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AGE <u>About 72 yrs.</u>	If LESS than 1 day, _____ hrs. or _____ min.?
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OCCUPATION  
(a) Trade, profession, or particular kind of work Messenger Bay Master

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Office

BIRTHPLACE  
(City or town, State or foreign country) Missouri 51

PARENTS	NAME OF FATHER <u>Not known</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>
	MAIDEN NAME OF MOTHER <u>Matilda Ray</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. H. Tyler

(ADDRESS) 2348 Michigan

Filed MAY -3 1912 Max C. Starkloff REGISTRAR

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

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 2<sup>nd</sup>, 1912

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from Ap. 30, 1912, to May 2<sup>nd</sup>, 1912, that I last saw him alive on May 2<sup>nd</sup>, 1912, and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Paralysis asc  
814  
824 Hemiplegia  
827 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory Cerebral Hemorrhage  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

(Signed) J. Meade Benson M. D.  
May 2, 1912 (Address) 240 Perdue

\*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>St. Peters</u>	DATE OF BURIAL <u>May 4</u> , 191 <u>2</u>
UNDERTAKER <u>W. C. Gordon</u>	ADDRESS <u>2649 Morgan</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, 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 \_\_\_\_\_  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City St Louis

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

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

Registration District No. 791 File No. 18320  
 Primary Registration District No. 1003 Registered No. 4123  
 (NO. 2921 Pine St. 23 Ward)

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

FULL NAME

Isaac Ray

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Mr.</u>	COLOR OR RACE <u>Col.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>
DATE OF BIRTH <u>Not known</u> , 18 <u>40</u> (Month) (Day) (Year)		
AGE <u>about 72</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. _____ min. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Messenger &amp; Railway</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Railroad office</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	NAME OF FATHER <u>not known</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>"</u>	
	MAIDEN NAME OF MOTHER <u>Magolda Ray</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 2, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 17, 1912, to May 2, 1912, that I last saw him alive on \_\_\_\_\_, 1912, and that death occurred, on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH\* was as follows:  
(Acute Paralysis asc)  
Hemiplegia  
Apoplexy  
 (Duration) \_\_\_\_\_ yr. \_\_\_\_\_ mos. 5 ds.

Contributory Cerebral Hemorrhage  
 (SECONDARY) arterial sclerosis  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

(Signed) J. Meade Benson M. D.  
May 2, 1912 (Address) 2400 Pendleton

\*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>St Peters</u>	DATE OF BURIAL <u>May 15</u> , 191 <u>2</u>
UNDERTAKER <u>W. C. Gordon</u>	ADDRESS <u>2649 Morgan</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. T. Tyler  
 (ADDRESS) 2348 Michigan

Filed 7-13- 1912 H. G. Brodgers REGISTRAR

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]

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**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, Sarcoma*, 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.)