

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	<i>Scotland</i>		Registration District No.	<i>813</i>	
Township	<i>Miller</i>		File No.	<i>34950</i>	
Village			Primary Registration District No.	<i>6062</i>	
City	(NO. _____)		Registered No.	<i>9</i>	
FULL NAME			St.	Ward	
<i>Island Clويد Riney</i>			[If death occurred in a hospital or institution, give its NAME instead of street and number]		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>Male</i>	<i>White</i>	<i>Single</i>	<i>October 3, 1912</i>		
DATE OF BIRTH		AGE	I HEREBY CERTIFY, that I attended deceased from		
<i>May 29, 1909</i>		<i>3 yrs 4 mos 8 ds.</i>	<i>September 28, 1912, to October 3, 1912,</i>		
		IF LESS than 1 day, _____ hrs. or _____ min.?	that I last saw him alive on <i>October 3, 1912,</i>		
OCCUPATION			and that death occurred, on the date stated above, at <i>10:12 p.m.</i>		
(a) Trade, profession, or particular kind of work <i>Infant</i>			The CAUSE OF DEATH* was as follows:		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>Infant</i>			<i>Acute Dysentery</i>		
BIRTHPLACE			<i>130</i>		
(City or town, State or foreign country) <i>Scotland Co Mo.</i>			<i>14</i>		
PARENTS	NAME OF FATHER	BIRTHPLACE OF FATHER	Contributory		
	<i>D. G. Riney</i>	<i>Mo.</i>	(Duration) _____ yrs. _____ mos. _____ ds.		
	MAIDEN NAME OF MOTHER	BIRTHPLACE OF MOTHER	(Signed) <i>D. D. Jay</i> M. D.		
	<i>Ana M. Reed</i>	<i>Mo.</i>	<i>Oct 4, 1912</i> (Address) <i>Pelaski Ia.</i>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
(Informant) <i>J. M. Reed</i>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
(ADDRESS) <i>Township MO</i>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Filed <i>Oct 4, 1912</i>		Where was disease contracted if not at place of death?			
<i>H. C. Finch</i> REGISTRAR		Former or usual residence _____			
		PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL		
		<i>Downing</i>	<i>Oct 3, 1912</i>		
		UNDERTAKER	ADDRESS		
		<i>Dee Riley</i>	<i>Downing</i>		

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 *surgi* al 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

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PLACE OF DEATH

County Scotland
 Township Miller
 or
 Village _____
 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. 813 File No. 34950
 Primary Registration District No. 6062 Registered No. 9

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

FULL NAME Leland Clويد Triney

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH May 29, 1909
(Month) (Day) (Year)

AGE 3 yrs. 4 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS
 NAME OF FATHER D. C. Triney
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
 MAIDEN NAME OF MOTHER Lucy M. Reed
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. M. Reed
 (ADDRESS) Downing, Mo.

Filed Oct 4 1912 H. C. Finch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 3, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 28, 1912 to Oct. 3, 1912
 that I last saw him alive on Oct. 3, 1912
 and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:
Acute dysentary
 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____
 (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) D. D. Jay M. D.
Oct. 4, 1912 (Address) Pulaski Pa.

*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 Hitt, Mo X DATE OF BURIAL Oct. 5, 1912
 UNDERTAKER Dre Riley X ADDRESS Downing

Revised United States Standard Certificate of Death

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

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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 septicæmia," "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.)