

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

PLACE OF DEATH

County Randolph

Township _____

or _____

Village _____

or _____

City Moberly, Mo.

Registration District No. 135

File No. 40273

Primary Registration District No. 3034

Registered No. 192

No. 719 N. End. St. -St. 4 Ward

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

FULL NAME

Mrs. D. Young

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May, Day 1, 1865 (Month) (Day) (Year)

AGE 47 yrs. 7 mos. - 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)

BIRTHPLACE (City or town, State or foreign country) Illinois

NAME OF FATHER Jacob Young

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

MAIDEN NAME OF MOTHER Elizabeth Stuyve

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. A. Jacob

(ADDRESS) Moberly, Mo.

Filed 12/4/1912 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 1st, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov-30, 1912, to Dec 1st, 1912, that I last saw him alive on Dec 1st, 1912, and that death occurred, on the date stated above, at 9:25 A.M.

THE CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(Duration) _____ yrs. _____ mos. 3 ds.

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

(Signed) Stuart John M. D. 1912 (Address) Moberly 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 Oakland Cemetery DATE OF BURIAL Dec. 2, 1912

UNDERTAKER Martin and Mahan ADDRESS Moberly Mo.

Person should be careful to state EXACTLY, PLACE, AGE should be properly classified. Exact statement of OCCUPATION

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*, *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.)

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RE-BUREAU OF VITAL STATISTICS
 CEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW. CERTIFICATE OF DEATH

PLACE OF DEATH

County Pandolph
 Township _____
 or _____
 Village _____
 or _____
 City Moberly (NO. 719 W. End St.; _____ Ward)

Registration District No. 735 File No. _____
 Primary Registration District No. 3034 Registered No. 192

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

FULL NAME Wm. W. Young

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>May</u> 18 <u>65</u> <small>(Month) (Day) (Year)</small>		
AGE <u>47</u> yrs. <u>7</u> mos. <u>7</u> ds. <small>If LESS than 1 day, ___ hrs. or ___ min.?</small>		
OCCUPATION <u>Had no occupation - never did work - was mentally</u> <small>(a) Trade, profession, or particular kind of work</small> <small>(b) General nature of industry, business, or establishment in which employed (or employer)</small>		
BIRTHPLACE <u>Ill.</u> <small>(City or town, State or foreign country)</small>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Dec. 1 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 30, 1912, to Dec. 1, 1912
 that I last saw him alive on Dec. 1, 1912
 and that death occurred, on the date stated above, at 9.25 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy

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

PARENTS	NAME OF FATHER <u>Jacob Young</u>
	BIRTHPLACE OF FATHER <u>Maryland</u> <small>(City or town, State or foreign country)</small>
	MAIDEN NAME OF MOTHER <u>Elizabeth Stager</u>
	BIRTHPLACE OF MOTHER <u>Maryland</u> <small>(City or town, State or foreign country)</small>

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

(Signed) J. Curtis Lester M. D.
11/4 1912 (Address) Moberly Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. A. Jacob
 (ADDRESS) Moberly, Mo.

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 _____

Filed 12/4/12 1912 W. Beaman REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Oakland Cem.</u>	DATE OF BURIAL <u>Dec. 2</u> 191 <u>2</u>
UNDERTAKER <u>Martin and Mahan</u>	ADDRESS <u>Moberly</u>

N. B. - Every item of information furnished is to be carefully supplied, classified, and exact statement of cause of death must be given. CAUSE OF DEATH
 PHYSICIANS should state exact statement of cause of death.

SUPPLEMENTARY

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*.

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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 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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