

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

PLACE OF DEATH
County Monroe ✓
Township South Fork Registration District No. 536 File No. 2072
or
Village _____ Primary Registration District No. 5784 Registered No. 1
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Frank Jaylore

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Jan Dec 3, 1882
(Month) (Day) (Year)
AGE 30 yrs. 1 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS:
NAME OF FATHER Jacob Taylor
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Hellen Woodyard
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R R Taylor
(ADDRESS) Malino Mo.

Filed Jan 22, 1913 John S Drake
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 7, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to Jan. 6, 1913,
that I last saw him alive on Jan. 6, 1913,
and that death occurred, on the date stated above, at 2:40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
23A
(Duration) 10 yrs. 10 mos. 0 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Flynt M. D.
Jan 8, 1913 (Address) Malino

*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 Berea Church DATE OF BURIAL Jan 8, 1913

UNDERTAKER Snyder & Angus ADDRESS Santa Fe Mo

Property of Missouri State Board of Health, Department of Occidental

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*, *peritonacum*, 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.)



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

PLACE OF DEATH

County Morgan
 Township South Fork
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 5-86 File No. _____
 Primary Registration District No. 5784 Registered No. 1

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

FULL NAME Frank Taylor

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
DATE OF BIRTH <u>Dec 3 1882</u> (Month) (Day) (Year)		
AGE <u>30</u> yrs. <u>1</u> mos. <u>3</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Lumber</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>millinery</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Morgan County Ohio</u>		
PARENTS	NAME OF FATHER <u>Jacob Taylor</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Mrs. Woodyard</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1913, to Jan 6, 1913,
 that I last saw _____ alive on Jan 6, 1913,
 and that death occurred, on the date stated above, at 2:40 m.
 The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) _____ yrs. 10 mos. _____ ds.

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

(Signed) J. T. Flynn M. D.
Jan 8 1913 (Address) Molino

*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) B R Taylor
 (ADDRESS) Molino Mo
 Filled 3/9 1913 John S Drake
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Berea Church DATE OF BURIAL Jan 8 1913
 UNDERTAKER Myrtle Hanger ADDRESS Santa Fe Mo

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

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 recorded. If the cause of death is not stated, the certificate is null and void. WITH REGARD TO THIS IS A PERMANENT RECORD

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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2022

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