

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

PLACE OF DEATH

County Gentry
Township _____
or
Village _____
or
City Trenton Mo (NO. 312 E. 10th St) St. 4th Ward

Registration District No. 330

File No. 5053

Primary Registration District No. 3017

Registered No. 10

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

FULL NAME John Hynne

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Widower
MARRIED OR DIVORCED (Write the word)

DATE OF BIRTH May 27, 1840
(Month) (Day) (Year)

AGE 72 yrs. 9 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION County Collector
General nature of industry, business, or establishment in which employed (or employer) 2-13

BIRTHPLACE Faswell Co Virginia
(City or town, State or foreign country)

NAME OF FATHER Minor Hynne

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

MAIDEN NAME OF MOTHER Emily Peery

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Grace Stone
(ADDRESS) 307 E. 10th St

Filed Feb 4 1913 E. A. Duffey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 3 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 30, 1912, to Feb 2, 1913, that I last saw him alive on Feb 2, 1913,

and that death occurred, on the date stated above, at 7³⁰ p.m.

The CAUSE OF DEATH* was as follows:
Cardiac Remission

(Duration) 1 yrs. 6 ds.

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

(Signed) J. B. Knight M. D.
Feb 3 1913 (Address) Trenton 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 Nynne Cemetery DATE OF BURIAL Feb 4 1913

UNDERTAKER R. H. Hamley Co ADDRESS Trenton

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____

Ward) _____

FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------|---------------------------------|---|
| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| DATE OF BIRTH | (Month) _____, 191____ | (Day) _____, 191____ |
| 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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased fro. _____

that I last saw h_____ alive on _____, 191____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

Contributory

(Secondary) _____

(Signed) _____ (Duration) _____ yrs. _____ mos.

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Mechanism and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____

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

Filed

_____, 191____

REGISTRAR

PLACE OF DEATH

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

County Gentry
Township _____
or
Village _____
or
City Trenton

Registration District No. 330 File No. _____
Primary Registration District No. 3017 Registered No. 10
(NO. 312 E 10th St) St.: _____ Ward _____

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

FULL NAME

John Wynne

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 2, 1913
(Month) (Day) (Year)

DATE OF BIRTH May 22, 1840
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 31, 1912, to Feb 2, 1913, that I last saw him alive on ", 1913, and that death occurred, on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

AGE 72 yrs. 9 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Waverly Va

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Arterio Sclerosis (SECONDARY) don't know (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Minor Wynne

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

(Signed) J. H. Wright M. D.
Apr 20, 1913 (Address) Trenton Mo

MAIDEN NAME OF MOTHER Emily Perry

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

*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) Grace Strue

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 _____

(ADDRESS) 302 E 10th St

PLACE OF BURIAL OR REMOVAL Wynne Cem DATE OF BURIAL 2-4, 1913

Filed Apr 20, 1913 E. A. Dukes REGISTRAR.

UNDERTAKER R. H. Hensley Co ADDRESS Trenton

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, 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 septichaemia," "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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