

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 St. Clair
 Township Taber
 or
 Village _____
 or
 City _____ (No. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
 BUREAU VITAL STATISTICS
 CERTIFICATE OF DEATH

790
 16015-
 Registration District No. _____
 Primary Registration District No. _____
 F.No. 10494
 Registered No. 3

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

FULL NAME

John Hayes

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 25 1887
(Month) (Day) (Year)

AGE 66 yrs. 1 mos. 26 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work Carpenter
 (b) General nature of industry, business, or establishment in which employed (or employer) 5-08

BIRTHPLACE
(City or town, State or foreign country) Boulder Co. Colo.

PARENTS
 NAME OF FATHER Wilson T. Hayes
 BIRTHPLACE OF FATHER Ohio
(City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Mary Cross
 BIRTHPLACE OF MOTHER Ohio
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (informant) Geo Hayes
 (ADDRESS) Taberville Mo.

Filed Mar 23 1913 A. C. Davidson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 23 1913
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from Mar 23, 1913, to Mar 23, 1913, that I last saw him alive on Mar 22, 1913, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Coronary Artery
7813

W. J. Sproun
(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory W. J. Sproun
(Secondary) _____
(Signed) _____ M. D.
Mar 23 1913 (Address) Taberville 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 Taberville Cemetery DATE OF BURIAL Mar 24 1913
 UNDERTAKER Leonard Boch ADDRESS Taberville Mo.

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 nature of the business, and (b) the nature of the occupation. Additional line is should be used or *Spinner*, (b) *Cott* (a) *Foreman*; (b) worked on may never return Dealer, etc.; w Day laborer, Fa Women at home; household only (definite salary), i work, or At home as At school or port specifically domestic service, maid, etc. If the up on account o cupation at begi ness, that fact tired, 6 yrs. a c

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.),



V. S. FORM XXX

FROM

STATE BOARD OF HEALTH

Bureau of Vital Statistics

JEFFERSON CITY, . . . MISSOURI

To _____

_____ County

Missouri

DISEASE CAUSING
spect to time a
accepted term f
br *spinal fever*
cerebrospinal m

("Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum, etc.*, *Carcinoma*, *Sar-*

HUGH STEPHENS, JEFFERSON CITY.

