

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Boone

Township _____

Registration District No. 79File No. 38588a

or _____

Primary Registration District No. 4047Registered No. 38

Village _____

Primary Registration District No. 4047Registered No. 38

or _____

Primary Registration District No. 4047Registered No. 38City Sturgeon (NO. _____)City Sturgeon (NO. _____)City Sturgeon (NO. _____)

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

FULL NAME Geo. William Holloway

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)DATE OF DEATH Dec. 6, 1913
(Month) (Day) (Year)DATE OF BIRTH June 7th, 1823
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov. 28, 1913, to Dec 6, 1913,
that I last saw her alive on Dec 5, 1913,AGE 89 yrs. 5 mos. 29 ds. IF LESS than 1 day, ___ hrs. or ___ min.?and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____Acute Indigestion
11/26
6/9/13BIRTHPLACE (City or town, State or foreign country) Boone Co. Mo.1 yr. (Duration) ___ yrs. ___ mos. 8 ds.NAME OF FATHER Wm. UnknownContributory Same
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown(Signed) E. N. Gentry M. D.
Dec 7, 1913 (Address) SturgeonMAIDEN NAME OF MOTHER Unknown

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) UnknownLENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. HollowayWhere was disease contracted if not at place of death?
Former or usual residence.(ADDRESS) Sturgeon MoPLACE OF BURIAL OR REMOVAL Sturgeon Co. Mo DATE OF BURIAL 12-8-1913Filed Dec 7, 1913 A. O. M. Coates REGISTRARUNDERTAKER J. W. Coates ADDRESS Sturgeon Mo.

PHYSICIAN'S NAME AND ADDRESS, if applicable. AGE and SEX of informant, if different from that of the deceased. Exact statement of OCCUPATION is very important, if it may be properly classified.

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 *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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PLACE OF DEATH

County Bonne
Township _____
or
Village _____
or
City Sturgeon (NO. _____ St. _____ Ward _____)

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

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

Registration District No. 19 File No. _____
Primary Registration District No. 4047 Registered No. 38

FULL NAME Geo. William Holloway

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(If wife the word)

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

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 (of 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) _____

(ADDRESS) _____

Filed Dec 7 1913 A. R. M. Coates REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 6, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1913, to _____, 1913, that I last saw her alive on _____, 1913, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion followed by Auto Intoxication

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory Heart Failure
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. R. Gentry M. D.
117 1913 (Address) Sturgeon 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 _____ DATE OF BURIAL _____ 1913

UNDERTAKER _____ ADDRESS _____

DEC 1913

Original file, date _____, 19____ All information called for must be written on this Supplementary Certificate

Supplementary Information

Age should be stated EXACTLY. PHYSICIANS should state occupation if very important. Exact statement of occupation is very important.

Revised United States Standard Certificate of Death

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

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