

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.

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

1296

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City St. Louis

Registration District No. 791

File No. 41526

Primary Registration District No. 1003

Registered No. 11549

(NO. St. Louis, Mullamphy) Ward _____

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

FULL NAME Dr. Ephraim Magoon

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Male White Married

DATE OF BIRTH

March 17, 1849
(Month) (Day) (Year)

AGE

71 yrs. 9 mos. 12 ds.

IF LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

Physician 1860

(b) General nature of industry, business, or establishment in which employed (or employer)

1948
89

BIRTHPLACE
(City or town, State or foreign country)

Harmony Maine

NAME OF FATHER

Joseph Magoon

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

Harmony Maine

MAIDEN NAME OF MOTHER

Matilda Watson

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

Harmony Maine

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Magoon

(ADDRESS)

4423 N. 21st St

Filed

DEC 31 1913

Max Starkloff

REGISTRAR

DATE OF DEATH

Dec 29, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Dec 2nd, 1913, to Dec 29, 1913,

that I last saw him alive on Dec 29, 1913,

and that death occurred, on the date stated above, at 11⁴⁵ P m.

The CAUSE OF DEATH* was as follows:

Fracture seventh cervical vertebra

Fall down stairs Accident
(Duration) ___ yrs. ___ mos. 31 ds.

Contributory Paralysis
(SECONDARY)

(Duration) 2 yrs. ___ mos. 29 ds.

(Signed) C. A. Stone M. D.

Dec 30, 1913 (Address) 2230 College Ave.

*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. 31 ds. State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? 3837 Lee Ave

Former or usual residence 3837 Lee Ave

PLACE OF BURIAL OR REMOVAL

Wald Hills

DATE OF BURIAL

Jan 1, 1914

UNDERTAKER

Wagon Pull Co

ADDRESS

2826 N. Grand Ave.

Dr. Starkloff Deputy Registrar

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 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, peritoneum*, 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," "Anæmia" (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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 11549

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

FULL NAME Dr. Ephraim Mayorn

PERSONAL AND STATISTICAL PARTICULARS

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

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ min. 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) _____

(ADDRESS) _____

Filed 12/31 1913 3.9.6. Anadgias REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, _____, 191____
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 1913, to _____, 1913,
that I last saw him alive on _____, 1913,

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

THE CAUSE OF DEATH* was as follows:
Fracture skull convex
VertexFull blown status accident
(Duration) _____ yrs. _____ mos. _____ ds.Contributory Paralysis (Quadriplegia)
(SECONDARY) below injury
motor sensory (Duration) _____ yrs. _____ mos. _____ ds.(Signed) L. C. Stone M.D.
ME 803 1913 (Address) 2230 College Dr

*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 _____, 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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