

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.

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

PLACE OF DEATH

County Shelby
Township Black Creek Registration District No. 831 File No. 41680
or
Village _____ Primary Registration District No. 6092 Registered No. 34
or
City Shelby County Infirmary St. _____ Ward _____

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

FULL NAME Robert Railor

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>Don't know</u> (Month) (Day) (Year)		
AGE <u>About 47</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer Sew'd</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Shelby County, Mo.</u>		
PARENTS	NAME OF FATHER <u>Geo. Railor</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>not known Larrick</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 22, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1912, to one visit, 1912, that I last saw him alive on Aug, 1912, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
82 F.
followed by (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Paralysis Sew'd (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. C. Selzer M. D.
12-22, 1913 (Address) Shelbyville 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 2 yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?
Former or usual residence 600 Infirmary

PLACE OF BURIAL OR REMOVAL <u>Shelby, Mo.</u>	DATE OF BURIAL <u>Nov 23</u> , 191 <u>3</u>
UNDERTAKER <u>J. W. Thompson & Son</u>	ADDRESS <u>Shelbyville, Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Railor
(ADDRESS) Shelby, Mo.

Filed Dec 22 1913 W. T. Carson
REGISTRAR

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

NOTE—Every item of information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex-

cept in the case of deaths from violence, such as homicide, suicide, or death from fire, explosion, lightning, or other natural causes, the cause of death should be stated in plain terms.

County _____

Township _____ or Village _____ or City _____ (NO. _____) _____ St. _____ Ward _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

FULL NAME _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____, (Month) _____, 191____, (Day) _____, 191____, (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed) _____, 191____ (Address) _____ M. D. _____

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

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

*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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____ (If give the word)

DATE OF BIRTH _____, 191____, (Month) _____, 191____, (Day) _____, 191____, (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 (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) _____

PLACEMENT OF BIRTH OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Filed _____, 191____ REGISTRAR _____

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County

Shelby
Black Creek

Registration District No.

831

File No.

Village

Primary Registration District No.

6092

Registered No.

City

(NO)

St.

Ward)

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

FULL NAME

Robert Failor

PERSONAL AND STATISTICAL PARTICULARS

SEX *M* COLOR OR RACE *W* SINGLE MARRIED OR DIVORCED OR WIDOWED *M.*
(Write the word)

DATE OF BIRTH _____, *1* _____, 191____
(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 (or employer) _____

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

PARENTS
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 *126* 191____ *4* _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 22, 191____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h. _____ live on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage
Cause not known

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory *General Paralysis*
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *B. E. Salgey* M. D.
1223 191____ (Address) *Shelbyville*

*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 _____

FADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information is CAUSE OF DEATH in plain terms, so that

SUPPLEMENTARY

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) *Colton 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

41636
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.)