

## PLACE OF DEATH

County ButlerTownship ash Grove

Village \_\_\_\_\_

City Fossil (NO. \_\_\_\_\_)MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 925

File No. \_\_\_\_\_

319

Primary Registration District No. 5134CRegistered No. 2

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

FULL NAME William Henry Aury

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

WhiteSINGLE  
MARRIED married  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH

Jan 20 1914  
(Month) (Day) (Year)

DATE OF BIRTH

April 12 1884  
(Month) (Day) (Year)

AGE

29 yrs. 9 mos. 19 ds.IF LESS than  
1 day, \_\_\_ hrs.  
or \_\_\_ min.?I HEREBY CERTIFY, that I attended deceased from  
Jan 20, 1914, to Jan 20, 1914,that I last saw him alive on Jan 20, 1914,and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH\* was as follows:

Hoarse Runy fever +  
+ was run over by  
wagon  
(Duration) 10 yrs. 6 mos. 6 hrs. ds.

Contributory

(SECONDARY)

(Duration) 10 yrs. 6 mos. 6 hrs. ds.(Signed) V. L. Greathouse

M. D.

Jan 7, 1914 (Address) Fossil 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

ash Grove

DATE OF BURIAL

Jan 21, 1914

UNDERTAKER

James Warr

ADDRESS

Fossil Mo

Filed

Jan 21, 1914

REGISTRAR

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.

# 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.)

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

PLACE OF DEATH  
County Bueller  
Township Ash Hill  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 925 File No. \_\_\_\_\_  
Primary Registration District No. 51340 Registered No. 2

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

FULL NAME William H Avery

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>April 12, 1844</u> (Month) (Day) (Year)		
AGE <u>72</u> yrs. <u>9</u> mos. <u>19</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Revere</u>		
PARENTS	NAME OF FATHER <u>Levi K. Kinn</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>	
	MAIDEN NAME OF MOTHER <u>Not known</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Jan 19, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 19, 1914, to Jan 19, 1914, that I last saw him alive on Jan 19, 1914, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:  
Horses run away  
was run over by wagon

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 hrs.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. L. G. G. G. M. D.  
1-20, 1914 (Address) Fish Mo

\*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) Emmeline Avery  
(ADDRESS) Nye Mo

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 \_\_\_\_\_

Filed Jan 20, 1914 W. L. G. G. G.  
REGISTRAR

PLACE OF BURIAL OR REMOVAL  
Ash Hill  
DATE OF BURIAL  
Jan 21, 1914  
UNDERTAKER  
James Warren  
ADDRESS  
Fish Mo

Copy

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. IN UNFADING INK—THIS IS A PERMANENT RECORD

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

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