

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

PLACE OF DEATH
County Montgomery
Township _____
or _____
Village Danville MO
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 588 File No. 20020
Primary Registration District No. 4326 Registered No. 4

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

FULL NAME Jesse M Synck

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDDED OR DIVORCED Single
(Write the word)

DATE OF BIRTH April 2, 1914
(Month) (Day) (Year)

AGE 2 yrs. 2 mos. 17 ds. IF LESS than 1 day, ___ hrs. ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work 9
(b) General nature of industry, business, or establishment in which employed (or employer) 118

BIRTHPLACE (City or town, State or foreign country) Danville MO

NAME OF FATHER Joe Synck

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

MAIDEN NAME OF MOTHER Katie Dooley

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Synck
(ADDRESS) Danville MO

Filed June 22, 1914

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from June 14, 1914, to June 19, 1914, that I last saw him alive on June 18, 1914, and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows;
Acute indigestion & exhaustion
(Duration) yrs. 3 mos. 2 wks. 0 ds.

Contributory Whooping cough
(Secondarily) (Duration) yrs. 2 mos. 2 wks. 0 ds.

(Signed) G. E. Murrill M. D.
June 19, 1914 (Address) Montgomery, 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 Burgoy Cemetery DATE OF BURIAL 6/20, 1914

UNDERTAKER #1484 ADDRESS C. W. Hopkins, Montgomery MO

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*, *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*, *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.)

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

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

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

County Montgomery Co
Township Sawville
Village Sawville
City _____

Registration District No. 588 File No. _____
Primary Registration District No. 1346 Registered No. 4
City _____ (No. _____ St. _____ Ward _____)

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

FULL NAME

Jesse H Lynes

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (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 6/22 1914 W. W. Daniels REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 6/19 1914 (Month) _____ (Day) _____ (Year)

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

The CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____ 191____ (Address) _____

*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 _____ 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 Elinor McQuinn Sawville ADDRESS _____

SUPPLEMENTARY Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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