

MARGIN RESERVED FOR BINDING

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 Washington
Township Washington or Ashe
Village Ashe
City _____ (NO. _____ St.; _____ Ward)
Registration District No. 228 File No. 25075
Primary Registration District No. 6177 Registered No. _____

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

FULL NAME James P. Boyer

PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the number)
DATE OF BIRTH May 12, 1878
(Month) (Day) (Year)
AGE 66 yrs. 1 mos. 26 ds. IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Mining

DATE OF DEATH 7 / 8 / 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to none, 191____,
that I last saw h____ alive on _____, 191____,
and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:
unknown but not suspicious

BIRTHPLACE (City or town, State or foreign country) Washington Richwoods

(Duration) 10 yrs. 2 mos. 2 ds.

NAME OF FATHER Theophilus Boyer

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

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

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

MOTHER NAME OF MOTHER Mashea Regonia

*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) Low Village

LENGTH 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) Lavina Boyer

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

(ADDRESS) Perth

PLACE OF BURIAL OR REMOVAL Old mine DATE OF BURIAL _____ 191____

Filed 7/8 191____ J. P. Boyer REGISTRAR

UNDERTAKER none ADDRESS none

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, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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.)



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V. S. NO. 2.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
County Washington
Township Kempston
or
Village
or
City

Registration District No. 976
Primary Registration District No. 6137
File No.
Registered No.
Ward

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

FULL NAME James P. Boyer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH
(Month) (Day) (Year)

AGE
If LESS than 1 day, hrs. or min. yrs. ds.

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 7/9 1914 James P. Boyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7-28, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1914, that I last saw h _____ alive on _____, 1914.

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) J. B. Stearns M. D.
Sept 5 1914 (Address) Blackwell

*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 1914

UNDERTAKER

Revised United States Standard Certificate of Death

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

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