

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

PLACE OF DEATH
County Grady
Township Maple
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 379
Primary Registration District No. 5437

File No. 25909
Registered No. 18

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

FULL NAME Winfield S Kent

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

DATE OF DEATH Aug 27 1914
(Month) (Day) (Year)

DATE OF BIRTH Sept 18 1848
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8-27, 1914, to 8-27, 1914, that I last saw him alive on 8-27, 1914

AGE 65 yrs. 11 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 8 a.m.

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

The CAUSE OF DEATH* was as follows:
Paralysis of heart

BIRTHPLACE (City or town, State or foreign country) Sullivan Co Mo

81A (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER William Kent

Contributory indis criminal spinal lesion (SECONDARY) (Duration) 3 yrs. ___ mos. ___ ds.

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

(Signed) G F Weir M. D. 8-27 1914 (Address) Logansport Mo

MAIDEN NAME OF MOTHER Mary Hoge

*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) Calum

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) D. L. Kent

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(ADDRESS) Logansport Mo

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

Filed Aug 30 1914 W P Pittman REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Berry DATE OF BURIAL Aug 29 1914

UNDERTAKER Carpenter Bros Logansport Mo ADDRESS _____

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*, *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," "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.)

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH Trudy
County Mys
Township _____
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 329 File No. _____
Primary Registration District No. 5457 Registered No. 18

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

FULL NAME Winfred S. Keut

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 27, 1914
(Month) (Day) (Year)

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

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

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

and that death occurred, on the date stated above, 80 m.
The CAUSE OF DEATH* was as follows:

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

Paralysis of Heart
Bulbar Paralysis
63

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

(Duration) _____ mos. _____ ds.

NAME OF FATHER _____

Contributors Indesense of great lesion
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) E. F. Mir M. D.
Aug 27, 1914 (Address) Osgood Mo

MAIDEN NAME OF MOTHER _____

*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) _____

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) _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMAINS _____ DATE OF BURIAL _____, 1914

Filed Aug 30 1914 W. P. Pittman REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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