

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.

DEATH RECORD

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

PLACE OF DEATH: Nodaway
County: Nodaway
Township: _____ or Village: _____ or City: Hopkins
Registration District No. 624 File No. 26867
Primary Registration District No. 4375 Registered No. 15

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

FULL NAME: Thomas Lafayette

PERSONAL AND STATISTICAL PARTICULARS

SEX: m COLOR OR RACE: w SINGLE MARRIED WIDOWED OR DIVORCED: widowed
DATE OF BIRTH: Sept 17, 1823
AGE: 90 yrs 10 mos 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: M. D.
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Lyon, France

PARENTS: NAME OF FATHER: Unknown
BIRTHPLACE OF FATHER: Unknown
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER: Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): O. H. Bayler
(ADDRESS): Hopkins Mo
Filed Aug 17, 1914 Norman Lowrey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug 16, 1914
I HEREBY CERTIFY, that I attended deceased from Aug 10, 1914, to Aug 16, 1914, that I last saw him alive on Aug 16, 1914, and that death occurred, on the date stated above, at 5:30 p. m.
The CAUSE OF DEATH* was as follows:

Nephritis
1911
10.5.89 (Duration) ___ yrs. ___ mos. 20 ds.

Contributory: Edema of Glottis
(Secondary) (Duration) ___ yrs. ___ mos. 6 ds.
(Signed) D. A. Surrency M. D.
Aug 17, 1914 (Address) Hopkins 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 REGENT 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: Hopkins Mo
DATE OF BURIAL: 8/17, 1914
UNDERTAKER: O. H. Bayler
ADDRESS: Hopkins Mo

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.)

WITH FADING 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.

PLACE OF DEATH
Indaway

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

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

County *Indaway* Registration District No. *624* File No. _____
Township _____ or _____ Village _____ or _____ City *Hopkins* (NO. _____ St.: _____ Ward _____)

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH *Aug 16*, 191*4*
(Month) (Day) (Year)

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

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that satisfactory information supplied.

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

and that death occurred, on the date stated above, at _____ 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 (or employer) _____

Phosphorus Chronic
(duration unknown)

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

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

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) _____

Contributor (Secondary) *Edwena Glott* (Duration) _____ yrs. _____ mos. _____ ds. (Signed) *P. G. Sargent* M. D. (Address) *Hopkins Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

State the Disease Causing Death, or, in deaths from Violent Causes, state Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(ADDRESS) _____

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? _____

Filed *Aug 17* 191*4* *W. Harmon Lowrey* REGISTRAR

Former usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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