

WRITE PLAINLY, WITH UNFADEING 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 Pettis

Township Sedalia

Village _____

City Sedalia (NO. _____ St. _____ Ward _____)

Registration District No. 668

File No. 26941

Primary Registration District No. 3052

Registered No. 193

FULL NAME George Yost

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH April 10th, 1876
(Month) (Day) (Year)

AGE 38 yrs. 4 mos. 0 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer) city street work

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

PARENTS NAME OF FATHER don't know
BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know
MAIDEN NAME OF MOTHER don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Yost
439 (ADDRESS) West 9th & Olive

Filed 8/12 1914 H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 10, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 9, 1914, to Aug. 10, 1914, that I last saw him alive on Aug. 10, 1914, and that death occurred, on the date stated above, at 4:30 p.m. The CAUSE OF DEATH* was as follows:

congestive chill
36 (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) E. F. Strat M. D.
Aug. 11, 1914 (Address) 104 North Main, Sedalia

*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 Crown Hill Cemetery DATE OF BURIAL Aug 12, 1914

UNDERTAKER Purbaugh & Allen Tax Co ADDRESS Sedalia, Mo.

PLACE OF DEATH

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

County _____ Township _____ or Village _____ or City _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 (NO. _____) St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	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) _____	
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 _____, 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

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

The CAUSE OF DEATH* was as follows:

BIRTHPLACE

(City or town, State or foreign country) _____

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) _____

Contributory (SECONDARY)

(Signed) _____

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

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

(Address) _____ M. D.

*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. 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

UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF BIRTH
Illinois

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

County _____
Township _____ or Village _____ or City _____ (NO. _____) St. _____ Ward _____
Registration District No. *668*
Primary Registration District No. *3032*
File No. _____
Registered No. *193*

FULL NAME *George Yost,*
(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 *M*
(If write the word)

DATE OF DEATH *Aug. 10*, 191*4*
(Month) (Day) (Year)

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

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

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

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) _____

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

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

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *E. A. Staats* M. D.
Aug 11, 191*4* (Address) *Sedalia Mo.*

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) _____

*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 _____

Filed *Nov. 1*, 191*4* *A. B. Coup*
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____
Satisfactory information supplied

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"); *Loabar 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.)