

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

28869

PLACE OF DEATH

County Daviess
Township Jamesport
or Village Jamesport
or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 252 File No. _____
Primary Registration District No. 4152 Registered No. 15

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

FULL NAME Unnamed Traylor

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If more than one word)

DATE OF BIRTH Jan. 22, 1914
(Month) (Day) (Year)

AGE 6 yrs. 2 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION Trade, profession, or particular kind of work none

General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) Jamesport Missouri

PARENTS

NAME OF FATHER J. C. Traylor

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

MAIDEN NAME OF MOTHER Artie Haral

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. C. Haral

(ADDRESS) Jamesport Mo.

Filed Sept 5 1914 C. M. Kniley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 14, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 12, 1914, to Aug 14, 1914, that I last saw him alive on Aug 14, 1914, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:
Transition

1180
158 (Duration) ___ yrs. ___ mos. ___ ds. ✓

Contributory (SECONDARY) Indigestion
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. D. Wagner M. D.
(Address) Jamesport 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 Madison DATE OF BURIAL Aug 15, 1914

UNDERTAKER W. H. Anderson ADDRESS Jamesport Mo

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) *Colton 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"); *Eobar 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.)

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

PLACE OF DEATH

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Ownership or Village or City *Jamesport*

Registration District No. *252*
Primary Registration District No. *4152*

File No. _____
Registered No. *15*

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

FULL NAME *Unnamed Exell*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH *Aug 14*, 191*4*
(Month) (Day) (Year)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Satisfactory Information Supplied.*
that I last saw h_____ alive on _____, 191____
and that death occurred, on the date stated above, at *12* 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) _____

Mention from unknown cause, usually classified as diabetic metabolism

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

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

NAME OF FATHER _____

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

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

MAIDEN NAME OF MOTHER _____

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

*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 REGULAR RESIDENTS)

At place of death _____ 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 REMOVAL _____ DATE OF BURIAL _____ 191____

FILE NO. *915* 191____ *H. C. McNeill* REGISTRAR

UNDERTAKER _____ ADDRESS _____

Supplied. properly.

Satisfactory Information Supplied.
SUPPLEMENTARY
Satisfactory Information Supplied.
Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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