

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

PLACE OF DEATH
County Ray
Township Orrick
or
Village
or
City (NO. St. Ward)

Registration District No. 743 File No. 30101
Primary Registration District No. 2978 Registered No. 29

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

FULL NAME fred lewms banyer

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Jan 10 1891 (Month) (Day) (Year)
AGE 23 yrs. 9 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Sept 28 1914 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Dec 23 1913 to Sept 28 1914, that I last saw him alive on Sept 28 1914, and that death occurred, on the date stated above, at 1 P.M.

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

The CAUSE OF DEATH* was as follows:
Passive Malnutrition
79A
186A
18923 (Duration) yrs. mos. 14 ds.

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

Contributory Injury of chest (SECONDARY) (Duration) yrs. mos. 5 ds.
(Signed) L. J. Ellis M. D.
Sept 24 1914 (Address) Orrick Mo

PARENTS NAME OF FATHER Wm Banyer

*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 FATHER (City or town, State or foreign country) Ray Co Mo

MAIDEN NAME OF MOTHER Milvada Bracken

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ray Co Mo

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

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

PLACE OF BURIAL OR REMOVAL South Point DATE OF BURIAL Sept 29 1914
UNDERTAKER Ed Rowland ADDRESS Orrick Mo

(ADDRESS) Orrick Mo

Filed Sept 24 1914 L. J. Ellis REGISTRAR

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*, *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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Ray
Township Orick
Village
City

Registration District No. 143
Primary Registration District No. 5978

File No.
Registered No. 29

FULL NAME

Fred C Lawrence Conyers

(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 Male COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED W.
(Write the word)

DATE OF DEATH 9/28/1914
(Month) (Day) (Year)

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

AGE
IF LESS than 1 day, hrs or min
yrs. mos. min.

I HEREBY CERTIFY, that I attended deceased from 9/28/1914 to 9/28/1914, that I last saw h. alive on 9/28/1914, and that death occurred, on the date stated above. 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)

Passive Meningitis
Free on chair back which passed upward to bladder
Duration 9 yrs. 5 mos. 5 ds.
Secondary Injury to Rectum
Duration 9 yrs. 5 mos. 5 ds.

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 Oct 27 1914 L. G. Kelly REGISTRAR

(Signed) L. G. Kelly M. D.
Orick Mo
1914 (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

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

UNDERTAKER ADDRESS

SUPPLEMENTARY Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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