

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

PLACE OF DEATH

County Montgomery
Township Soutie
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 594 File No. 32326
Primary Registration District No. 5288B Registered No. 10

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

FULL NAME John G. B Kendrick

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Oct-27, 1914
(Month) (Day) (Year)

DATE OF BIRTH June 17, 1876
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct-19, 1914, to Oct-27, 1914, that I last saw him alive on Oct-25, 1914, and that death occurred, on the date stated above, at 8a m. The CAUSE OF DEATH* was as follows:

AGE 88 yrs. 4 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

acute Bronchitis
82D
106A (Duration) ___ yrs. ___ mos. 7 ds.
Contributory Paralysis
(SECONDARY) (Duration) ___ yrs. ___ mos. 2 ds.

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

BIRTHPLACE (City or town, State or foreign country) Lexington Ky

PARENTS
NAME OF FATHER Not known
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky.
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

(Signed) A. J. Busch M. D.
Oct-28, 1914 (Address) Rhineclaud

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Dowling
(ADDRESS) Rhineclaud 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 _____

Filed 10-28, 1914. C. R. Rauschellbach
REGISTRAR

PLACE OF BURIAL OR REMOVAL Kendrick Cemetery DATE OF BURIAL 10-28, 1914
UNDERTAKER B. R. Baker ADDRESS Amicus Mo

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*, *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, 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.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH
 County Wray
 Township Linton
 or
 Village _____
 or
 City _____

Registration District No. 594 File No. _____
 Primary Registration District No. 5788B Registered No. 10
 St.: _____ Ward) _____

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

FULL NAME John G B Keudner

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH <u>June 17, 1876</u> (Month) (Day) (Year)		
AGE <u>68</u> yrs.		If LESS than 1 day, ___ hrs. or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>James supplied</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Lenington, Ky</u>		
PARENTS	NAME OF FATHER <u>Don't know</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>Don't know</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>		

DATE OF DEATH Oct 27, 1914
 (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 SA.

The CAUSE OF DEATH* was as follows:
Acute Bronchitis
Paralysis Acute

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

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

(Signed) J. Burch M. D.
 Oct 28, 1914 (Address) Rhineclaud 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? _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. J. Dowling
 (ADDRESS) Rhineclaud Mo
 Filed 10/28 1914 408 Rauschellbach
 REGISTRAR B. A. Baker

PLACE OF BURIAL OR REMOVAL Hendrick Cemetery
 DATE OF BURIAL 10-28, 1914
 UNDERTAKER B. A. Baker
 ADDRESS Americus Mo

Revised United States Standard Certificate of Death

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

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