

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

1 PLACE OF DEATH

County Levon
Township Lyon
or
Village
or
City

Registration District No. 483 File No. 1622
Primary Registration District No. 5647 Registered No. 1
City (NO. St. Ward)

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

2 FULL NAME

Maxim Keith Hayden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Dec 27</u> 1914 (Month) (Day) (Year)		
7 AGE yrs. mos. 4 ds.		If LESS than 1 day..... hrs. or..... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Not any</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Not any</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Benjamin Mo.</u>		
PARENTS	10 NAME OF FATHER <u>Ben J. Hayden</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	12 MAIDEN NAME OF MOTHER <u>Hazel H. Hughes</u>	
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>		

1 MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Dec 31 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 27 1914 to Dec 31 1914.
that I last saw him alive on Dec 30 1914 and that death occurred, on the date stated above, at 6.0 m.

The CAUSE OF DEATH* was as follows:

Overexhaustion of the Bronchi
1610 (Duration) yrs. 15 mos. 2 ds.

CONTRIBUTORY (Secondary)
(Signed) R. C. O. Shanks M. D.
Jan 2 1915 (Address) Canton Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 4 mos. 4 ds. In the State..... yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence Benjamin Mo.

19 PLACE OF BURIAL OR REMOVAL Benjamin DATE OF BURIAL Jan 2 1915

20 UNDERTAKER Not any ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben J. Hayden
(Address) Benjamin Mo.

15 Filed Jan 2 1915 R. D. Jennings Registrar

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.)

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

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. 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
Lewis
County *Lyon*
Township *Lyon*
or
Village
or
City

Registration District No. *H 83* File No. _____
Primary Registration District No. *5647* Registered No. *1*
(NO. _____) (St. _____) (Ward _____)

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

FULL NAME *Maxie Keith Hayden*

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 191____
(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)

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) _____

Filed *Jan. 2, 1915* *P. W. Janney*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Dec. 31, 1914*
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
hemorrhage of the bowels.
unknown
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *C. A. Shanks* M. D.
Jan. 2, 1915 (Address) *Canton, 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 _____ DATE OF BURIAL _____ 191____

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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1622

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