

INKING--THIS IS A PERMANENT RECORD

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 Douglas
Township Jackson
or
Village Buckhart
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1062 File No. 8059
Primary Registration District No. 5392 Registered No. 30

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

FULL NAME May Riley

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb 11 1915
(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) Buchard

PARENTS NAME OF FATHER John Riley BIRTHPLACE OF FATHER (City or town, State or foreign country) Douglas Mo MAIDEN NAME OF MOTHER Cassay McBlery BIRTHPLACE OF MOTHER (City or town, State or foreign country) Douglas Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) Alonso Riley (ADDRESS) Buchard

Filed Feb 12 1915 D G Ladue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 11 1915
(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:

unknown

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 191____ (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 Harrison Cemetery DATE OF BURIAL Feb 12 1915 UNDERTAKER Robt Hicks ADDRESS Buchard

WRITE PLAINLY, WITH UNFADING INK—

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 _____

Township _____ Registration District No. _____ File No. _____

or Village _____ Primary Registration District No. _____ Registered No. _____

or City _____ (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 OR DIVORCED (Write the word)
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DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

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 _____.

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) _____

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

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

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

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

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) _____

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

Filed _____, 191____

REGISTRAR _____

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE PLAINLY, WITH UNFAIR DENIAL - THIS IS A FORMAL RECORD

SUPPLEMENTARY

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

PLACE OF BIRTH _____
 County Douglas
 or Jackson
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St.: _____ Ward)

REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

REGISTRATION DISTRICT NO. 1062 File No. _____
 PRIMARY REGISTRATION DISTRICT NO. 5392 REGISTERED NO. 30

FULL NAME May Riley [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 <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>	DATE OF DEATH <u>Feb 11, 1901</u> (Month) (Day) (Year)	
DATE OF BIRTH _____ (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.	
AGE _____ yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.	The CAUSE OF DEATH* was as follows: <u>Unknown</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or, employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____			Contributory _____ (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER _____		(Signed) <u>Mrs. Ted Hicks midwife</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		191____ (Address) <u>Bechtel St.</u>	
	MAIDEN NAME OF MOTHER _____		*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 MOTHER (City or town, State or foreign country) _____		LENGTH OF RESIDENCE (FOR HOSPITALS; INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			Where was disease contracted If not at place of death? _____ Former or usual residence <u>Ind.</u>	
Filed <u>3/12</u> 19 <u>01</u> <u>S. D. Y. Ladd</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL: <u>St. Mary's</u>	DATE OF BURIAL _____ 19L_____
			UNDERTAKER _____	ADDRESS _____

Original file, date _____ 19____ All information called for must be written on this Supplementary Certificate.

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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

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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.)