

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

PLACE OF DEATH
County Howard
Township Richmond
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 378 File No. 30437
Primary Registration District No. 5526 Registered No. 44

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

FULL NAME James Moyer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Unknown unknown, 1857
(Month) (Day) (Year)

AGE About 58 yrs. mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?

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) Penn.

PARENTS
NAME OF FATHER Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. Wingfield
(ADDRESS) Hayette Mo.

Filed 10/8 - 1912 V. J. Rube
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 7th, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 5, 1911, to Oct 7, 1912, that I last saw him alive on Oct 7, 1912, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
175K
92A

(Duration) ___ yrs. ___ mos. 5 ds.

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

(Signed) C. O. Lewis M. D.
10/8 - 1912 (Address) Hayette 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 Hackley Family Cem. DATE OF BURIAL 10-8-1912

UNDERTAKER E. S. Shepherd ADDRESS Hayette 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*, *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, 8 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.)

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

1 PLACE OF DEATH

County Howard
 Township Richmond
 Village _____
 City _____

Registration District No. 378
 Primary Registration District No. 5526

File No. _____
 Registered No. 44

(NO. _____) (St. _____) (Ward _____)

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

2 FULL NAME

James Myer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

16 DATE OF DEATH Oct 7 1915
 (Month) (Day) (Year)

6 DATE OF BIRTH _____ (Month) _____ (Day) 1 _____ (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____.

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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

CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage from blow upon head probably homicidal
 (Duration) _____ yrs. _____ mos. 5 ds.

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

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

PARENTS 10 NAME OF FATHER _____ 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ 12 MAIDEN NAME OF MOTHER _____ 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

(Signed) E. L. Lewis M. D. 10/8 1915 (Address) Haystack

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____

*State the Disease Causing Death, or, in death 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 _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____ Former or usual residence _____

15 Filed 10/8 1915 W. B. Borchert Registrar

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

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Revised United States Standard Certificate of Death

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

30483

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