

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

PLACE OF DEATH

County Texas

Township Piney

Village Houston

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 203

Primary Registration District No. 6137

File No. 36580

Registered No. 331

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

FULL NAME G. T. Mires

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 27, 1851
(Month) (Day) (Year)

AGE 65 yrs. 2 mos. 24 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) Tennessee

NAME OF FATHER G. W. Mires

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Tenn.

MAIDEN NAME OF MOTHER E. A. Telford

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G. T. Mires
(ADDRESS) Houston

Filed 10-23 1916 J. W. Marshall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 21, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 20, 1916, to Oct 21, 1916 that I last saw him live on Oct 21, 1916 and that death occurred, on the date stated above, at 9 P.m.

The CAUSE OF DEATH* was as follows:
Fracture of spine due to fall
1868
1948 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) M. Punister M. D.
Oct 18 1916 (Address) Houston 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 Houston DATE OF BURIAL Oct 24, 1916

UNDERTAKER Rayford Elliott ADDRESS Houston Mo.

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

PLACE OF DEATH

County _____

Township _____

or Village _____

or City _____

(NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH _____

AGE _____

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)

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 _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____, 191 _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____

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:

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

Contributory

(SECONDARY)

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

(Signed) _____ 191 _____ (Address) _____ M. D.

*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 _____

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

1 PLACE OF DEATH
 County Jayas
 Township Piney
 or
 Village
 or
 City

Registration District No. 863 File No.
 Primary Registration District No. 6137 Registered No. 33
 St. Ward

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

2 FULL NAME G. F. Mixer

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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

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)

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

15 Filed 10/23 1916 G. J. W. Mack
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 21 1916
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
 1916 to 1916
 that I last saw him alive on 1916
 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Fracture of spine
due to fall accidentally
through hay soft
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) W. M. Phemister M. D.
Oct 21 1916 (Address) Houston

*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 yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Houston DATE OF BURIAL 1916

20 UNDERTAKER Rayford V. Elliott ADDRESS Houston

SUPPLEMENTARY
 INFORMATION SUPPLIED
 BY THE 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), 29ds.; *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.)