

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

1 PLACE OF DEATH

County Platte

Township _____

Village Edgerton

City _____

Registration District No. 692

Primary Registration District No. 4415

(NO. _____ St. _____ Ward _____)

File No. 38459

Registered No. _____

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

2 FULL NAME Velma Lucile Boydston

PERSONAL AND STATISTICAL PARTICULARS

3 SEX girl 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH Aug 13 1915
(Month) (Day) (Year)

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

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

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

10 NAME OF FATHER John Boydston

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

12 MAIDEN NAME OF MOTHER Lucile Smith

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John Boydston
(Address) Edgerton, Mo.

15 Filed Nov 9 1916. L. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 15 1916, to Sept 20 1916, that I last saw her alive on Sept 19 1916, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia
107A (Duration) 5 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. R. Mitchell M. D.
Sept 21 1916 (Address) Edgerton, Mo.

*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 _____

19 PLACE OF BURIAL OR REMOVAL Mt Zion Cemetery DATE OF BURIAL Sept 21 1916

20 UNDERTAKER Pallino & Davis ADDRESS Edgerton Mo

EXACTLY. PLEASE PRINT FULL NAME AND ADDRESS OF OCCUPANT ON LEAF BEHIND. IMPORTANT.

PARENTS

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, 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.)

B—Every item of information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PLACE OF DEATH *Kentucky*
 County *Edgeston*
 Township *Edgeston*
 Village *Edgeston*
 City *Edgeston*

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
 Registration District No. *693* File No. _____
 Primary Registration District No. *4415* Registered No. _____

FULL NAME *Velma Lucile Boydston* (NO. _____ St. _____ Ward _____)
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>F</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>W.</i>
6 DATE OF BIRTH (Month) _____ (Day) _____ 1 _____ (Year) _____ <i>Satisfactory information supplied</i>		
7 AGE yrs. _____ mos. _____ ds. _____		8 LESS than 1 day _____ hrs. or _____ min.?
9 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Satisfactory information supplied</i>		
10 BIRTHPLACE (City or town, State or foreign country)		
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)		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 20 1916*
 (Month) _____ (Day) _____ (Year) _____
 17 I HEREBY CERTIFY, that I attended deceased from _____ 191____ to _____ 191____
 that I last saw him _____ 191____
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:
Prone Pneumonia
 (Duration) _____ yrs. _____ mos. _____ ds. *5*

CONTRIBUTORY

(Secondary)
 (Signed) *A. P. Mitchell* _____ D.
9-21 1916 (Address) *Edgeston, Mo.*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
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 Where was disease contracted, if not at place of death?
 Former or usual residence _____

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

15 Filed *Nov 9 1917* *L. Davis* Registrar

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

38459

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Tuberculosis of lungs, meninges, peritonæum, 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 "Asthénia," "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.)