

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

41524

PLACE OF DEATH
County Stuart
Township Brooklet
or
Village
or
City Edinburg (NO. _____ St.: _____ Ward)

Registration District No. 441 File No. _____

Primary Registration District No. 4259 Registered No. 81

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

FULL NAME Anna V Boyzart

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH November 25th, 1916
(Month) (Day) (Year)

DATE OF BIRTH June 29, 1866
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from about Oct 1st, 1916, to Nov 20, 1916, that I last saw her alive on Monday 20th, 1916, and that death occurred, on the date stated above, at a m.

AGE 50 yrs. 9 mos. 28 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Housewife

166 878 158
(Duration) _____ yrs. _____ mos. _____ ds.

(b) General nature of industry, business, or establishment in which employed (or employer)

Contributory Nervousness (SECONDARY) several months
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE Edinburg Mo
(City or town, State or foreign country)

(Signed) J. A. Campbell M. D.
(Address) Edinburg Mo

NAME OF FATHER Charles D Boyzart

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

BIRTHPLACE OF FATHER Hicksville Mo
(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.

MAIDEN NAME OF MOTHER Cora Barker

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. C. Boyzart

Where was disease contracted if not at place of death? _____

(ADDRESS) Murrelland, Mo

Former or usual residence _____

Filed Dec. 10, 1916. H. J. Jurgens REGISTRAR

PLACE OF BURIAL OR REMOVAL Barker Care DATE OF BURIAL Nov 27, 1916

UNDERTAKER Wm. H. & J. J. Jurgens ADDRESS Edinburg Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____) _____ St. _____ Ward _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ SINGLE _____ MARRIED _____
 COLOR OR RACE _____ WIDOWED _____
 OR DIVORCED _____
 (If file the word)

DATE OF BIRTH _____ (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)

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) _____ (Day) _____, 191____

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:

Contributory
 (SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____
 _____ (Duration) _____ yrs. _____ mos. _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____
 Where was disease contracted if not at place of death?
 Former or usual residence _____

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *Max*
Township
or
Village
or
City *Edeua*

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

Registration District No. *441* File No.
Primary Registration District No. *4259* Registered No. *31*
St. Ward

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

2 FULL NAME

Cora V. Boyan

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

14 (Informant)
(Address)

15 *Dec 6 1916*
Full Name *G. J. Ferguson*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
191 *Nov 25* 191 *6*
(Month) (Day) (Year)

17 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

The CAUSE OF DEATH* was as follows:
Stroke by poisoning
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *S. D. Campbell* M. D.
(Address) 191

*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 DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

Original file, date *DEC 1916*, 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);

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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.)