

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

612

1 PLACE OF DEATH
County Clay
Township Excelsior Springs Registration District No. 198 File No. 612
or
Village _____ Primary Registration District No. 8011 Registered No. 6
or
City Excelsior Springs (NO. Playa Hotel, St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Augustine G. Haword

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 MARRIAGE: Widowed
SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)

6 DATE OF BIRTH Aug 10, 1863
(Month) (Day) (Year)

7 AGE 53 yrs 4 mos 29 ds. If LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER Nicholas Haword

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

12 MAIDEN NAME OF MOTHER W. Howell

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Am Howard
(Address) Excelsior Springs Mo

15 Filed Jan 11, 1917 T. N. Bogart Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 9, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 15, 1916 to Jan 9, 1917
that I last saw him alive on Jan 9, 1917
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:
Nephritis
13211
13213

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Ovarian

(Duration) yrs. mos. ds.

(Signed) Dr. Keith M. D.
Jan 10, 1917 (Address) Excelsior Springs Mo.

*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 10 yrs. mos. ds. In the 15 yrs. mos. ds.

Where was disease contracted if not at place of death? Exc Springs

Former or usual residence Exc Springs

19 PLACE OF BURIAL OR REMOVAL Charles Gro DATE OF BURIAL Jan 11, 1917

20 UNDERTAKER Trathout & Hope ADDRESS Exc Springs

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*, *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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Clay

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

Township

Registration District No.

198

File No.

Village

Primary Registration District No.

3011

Registered No.

6

City

G. Springs

(NO

Ploza Hotel

St.

Ward)

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

2 FULL NAME

Augustus G. Noward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

W

6 DATE OF BIRTH

(Month)

(Day)

(Year)

7 AGE

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
FATHER11 BIRTHPLACE
OF FATHER
(City or town, State or foreign country)12 MAIDEN NAME
OF MOTHER13 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

Jan 11, 1911

T. M. Boyack
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

Jan 9, 1911

17

I HEREBY CERTIFY, that I attended deceased from

, 1911, to , 1911,

that I last saw him alive on , 1911,

and that death occurred, on the date stated above, at . m.

The CAUSE OF DEATH* was as follows:

Nephritis
Parenchymatous

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. R. Smith M. D.
Jan 10, 1911 (Address) G. Springs, Mo.*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

, 1911

20 UNDERTAKER

ADDRESS

Original file, date JAN 11, 1911

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]

210

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