

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty WrightTownship ColonyRegistration District No. 1056File No. 648837

Village _____

Primary Registration District No. 6894Registered No. 39

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Glen Gilbert Kenoyer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)DATE OF BIRTH May 25, 1916
(Month) (Day) (Year)AGE 8 yrs. 22 mos. 22 ds. If LESS than 1 day, hrs. or min.?OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) NoneBIRTHPLACE (City or town, State or foreign country) Mo.PARENTS NAME OF FATHER Gilbert Kenoyer BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo. MAIDEN NAME OF MOTHER Bulah Price BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gilbert Kenoyer
(ADDRESS) Reitledge MoFiled Feb 17, 1917 C. E. Hoffman REGISTER

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 17, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan 8, 1917, to Feb 17, 1917, that I last saw him alive on Feb 16, 1917, and that death occurred, on the date stated above, at 10.0 m. The CAUSE OF DEATH¹ was as follows:
Pneumonia

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

(Signed) W. P. McKeyrholder M. D. Feb 17, 1917 (Address) Reitledge 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 _____ yrs. _____ mos. _____ ds.

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Colony DATE OF BURIAL July 18, 1917UNDERTAKER J. S. Kenoyer ADDRESS Reitledge Mo

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.)

Registration District No.

File No.

Primary Registration District No.

Registered No.

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX..... COLOR OR RACE..... SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (If wife, 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)..... 191.....

Filed..... REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH..... (Month)....., 191..... (Day)....., 191..... (Year).....
 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:

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

Contributory
 (SECONDARY)

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

(Signed)..... M. D.

191..... (Address)

*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..... 191.....

UNDERTAKER..... ADDRESS.....

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County *Monroe*
 Township *Colony*
 or
 Village
 or
 City

Registration District No. *1056* File No.
 Primary Registration District No. *5597* Registered No. *39*
 St. Ward

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

2 FULL NAME *Glen Gilbert Kenoyes*

PERSONAL AND STATISTICAL PARTICULARS

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

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)

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 *Feb. 17 1917*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from the time he/she was last seen alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pneumonia Broncho
 (Duration) *7* days yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) *Urial McReynolds* City, Mo. 191____ (Address) *Monroe City, 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.

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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191____

20 UNDERTAKER ADDRESS

15 Filed *Feb 17* 1917 Registrar

SUPPLEMENTARY

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, or 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.)

8840