

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

1 PLACE OF DEATH

County Linn

Township.....

Village.....

City La Grange (NO..... St..... Ward.....)

Registration District No. 480

File No. 9618

Primary Registration District No. 4289

Registered No. 10

2 FULL NAME Rayford Smith

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

16 DATE OF DEATH Mar 7 1918
(Month) (Day) (Year)

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

17 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.

7 AGE about 88 yrs..... mos..... ds. IF LESS than 1 day..... hrs. or..... min.?

The CAUSE OF DEATH* was as follows:

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

Not known found dead sitting in his chair

9 BIRTHPLACE (City or town, State or foreign country) Marion Co Mo

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

10 NAME OF FATHER.....

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.

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

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

12 MAIDEN NAME OF MOTHER Eloise Smith

....., 191..... (Address).....

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Albert Allen
(Address) La Grange Mo

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.....

15 Filed Mar 10 1918 W. L. Selley Registrar
By Wally Kuff

19 PLACE OF BURIAL OR REMOVAL La Grange DATE OF BURIAL Mar 10, 1918

20 UNDERTAKER A. H. Roberts ADDRESS La Grange Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. INFORMATION should be carefully supplied.

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, peritoneum*, 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.)

Exact statement of OCCUPATION is very important.

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.

PLACE OF DEATH

County

Lewis

Township

Village

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

480

4289

10

La Grange

St.: _____ Ward)

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

FULL NAME

Bluford Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

M

B

wid

DATE OF DEATH

Mar 7 1918

DATE OF BIRTH

unknown

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.

AGE

About 88

If LESS than 1 day, _____ hrs or _____ min. 7

The CAUSE OF DEATH* was as follows:

OCCUPATIONS

(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)

Contributory (SECONDARY)

(Signed)

*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant):

(ADDRESS)

Filed

W J Ellen
1918
By W J Ellen

REGISTRAR

Original file, date _____ 19____

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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8196
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