

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

3591

1. PLACE OF DEATH
 County Sullivan Registration District No. 852 File No.
 Township Park Primary Registration District No. 6120 Registered No. 3
 City (No.) St. Ward (No.)

2. FULL NAME Joseph Allen Sayre
 (a) Residence No. St. Ward
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 12 - 1911

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 11 8 24 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home Sewing Machine
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

3 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1923

17. I HEREBY CERTIFY That I attended deceased from 1-3-23 to 1-6-23 that I last saw him alive on 1-5-23, 1923, and that death occurred, on the date stated above, at 4 Jackson St

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tetanus (sue to open wound on foot)
1943 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Primum Capitem
 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Co Mo

10. NAME OF FATHER George Albert Sayre

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Co Mo

12. MAIDEN NAME OF MOTHER Roma Bennett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Co Mo

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Sp. Test
 (Signed) [Signature], M. D.
1/6, 1923 (Address) Milan Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT (Address) George Albert Sayre, Milan Mo

15. FILED 1-8, 1923 Bertie McCary REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove Cem Sullivan Co Mo DATE OF BURIAL Jan 7 1923

20. UNDERTAKER C. J. Schaene ADDRESS Milan Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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*, *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

1 PLACE OF DEATH

County Sullivan
 Township Park
 or
 Village _____
 or
 City _____ (No. _____ St.; _____ Ward)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. _____

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

2 FULL NAME Joseph Allen Squire

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M4 COLOR OR RACE W5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S.16 DATE OF DEATH Jan 6, 1923
(Month) (Day) (Year)6 DATE OF BIRTH April 12, 1911
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

7 AGE 11 yrs. 8 mos. 24 ds.

If LESS than 1 day, ____ hrs. or ____ min. ?

that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

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

The CAUSE OF DEATH* was as follows:

Retained (due to open wound on foot) - An operation while going to hospital last fall was done for about 4 days long time (Duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (State or country) _____

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.

PARENTS

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or country) _____

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) _____

15 _____, 191____

20 UNDERTAKER _____

ADDRESS _____

Filed _____, 191____

REGISTRAR _____

852
6120

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