

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

25730 <sup>a</sup>

**1. PLACE OF DEATH**

County Carter  
 Township Jackson  
 City Jackson (No.       )

Registration District No. 144  
 Primary Registration District No. 5207

File No. 15  
 Registered No. 4  
 St.        Ward       

**2. FULL NAME**

Ora Ray Beaver

(a) Residence. No.        St.        Ward         
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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) June

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
6 15

**8. OCCUPATION OF DECEASED**

none

- (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (if employer)  
 (c) Name of employer

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

10. NAME OF FATHER Ray Beaver

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

12. MAIDEN NAME OF MOTHER May Coates

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

14. INFORMANT Ray Beaver  
 (Address) Elk Grove Mo

15. FILED Nov 1924 Dr. McPherson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 3rd 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1924, to Sept 3, 1924 that I last saw        alive on Sept 1, 1924, and that death occurred, on the date stated above, at 5 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Dysentery

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED Mo

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF       

WAS THERE AN AUTOPSY?       

WHAT TEST CONFIRMED DIAGNOSIS?       

(Signed)       , M. D.  
 , 19        (Address)

\*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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Grisham Cemetery

DATE OF BURIAL

8/3 1924

20. UNDERTAKER

John Province

ADDRESS

Elk Grove Mo

# 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 (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.

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CERTIFICATE OF DEATH**

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County Carter  
Township Jackson  
City                      (No.                     )

Registration District No. 144  
Primary Registration District No. 5207

File No. 25730<sup>a</sup>  
Registered No. 4  
St.                      Ward                     

**2. FULL NAME**

Ora Ray Beavers

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) SS

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 18, 1924

7. AGE YEARS MONTHS DAYS 1 If LESS than 1 day,                      hrs. or                      min.

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN)                       
(STATE OR COUNTRY)                     

10. NAME OF FATHER                     

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

12. MAIDEN NAME OF MOTHER                     

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

14. INFORMANT                       
(Address)                     

15. FILED Nov 3, 1924 St. McPherson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3- 19 24

17. I HEREBY CERTIFY, That I attended deceased from                     , 19                     , to                     , 19                     ,  
(that I last saw h.                      ante on                     , 19                     , 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.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH:                     

DID AN OPERATION PRECEDE DEATH?                      DATE OF                     

WAS THERE AN AUTOPSY?                     

WHAT TEST CONFIRMED DIAGNOSIS?                     

(Signed) C. C. Sheets, M. D.  
, 19                      (Address)                     

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL                      DATE OF BURIAL                      19                     

20. UNDERTAKER                      ADDRESS                     

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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"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 neoplasm); *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.)

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