

27 1927

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

Do not use this space.

11568

1. PLACE OF DEATH

County Jackson
Township Sumner
City Blue Springs, Mo.

Registration District No. 398
Primary Registration District No. 4232

File No.
Registered No.
St. Ward)

2. FULL NAME Henry Clinton Mayo

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

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. - mos. - ds. How long in U.S., if of foreign birth? - yrs. - mos. - da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1927

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Wilson - Mayo

I HEREBY CERTIFY That I attended deceased from October 13, 1926 to April 21, 1927 (that I last saw him alive on April 21, 1927 and that death occurred, on the date stated above, at 2:00 AM p.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 1848

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 81 8 7

Arterio - Sclerosis

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY) Nephritis, Intestinal (duration) 3 yrs. - mos. - ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Simpson Co Ky

18. THERE WAS (DISEASE) CONTRIBUTED Place of death IF NOT AT PLACE OF DEATH? no DID AN OPERATION PRECEDE DEATH? no DATE OF.....

10. NAME OF FATHER Joel Mayo

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

12. MAIDEN NAME OF MOTHER Martha Bedan

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

14. INFORMANT (Address) Stella M Thornton Poplar Mo.

15. FILED Apr 25 1927 F.W. Scott REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Springs DATE OF BURIAL Apr 23 1927
20. UNDERTAKER J.W. Stanley Blue Springs Mo. 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.)

Exact statement of OCCUPATION is very important. Do not leave blank terms, so that it may be properly classified.

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; Broncho; pneumonia* ("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 neoplasma); *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 ⁴septicemia," "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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Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 395 File No.
 Township Blue Springs Primary Registration District No. 4232 Registered No.
 City Blue Springs (No.) St. Ward)

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 22 1927

17. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19....., that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at.....m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15-1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 8 17

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

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

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

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

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

10. NAME OF FATHER

WAS THERE AN AUTOPSY?.....

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

WHAT TEST CONFIRMED DIAGNOSIS?.....

12. MAIDEN NAME OF MOTHER

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

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

, 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.

14. INFORMANT (Address)

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

15. FILED 7/1 1927 J. N. Frittle REGISTRAR

20. UNDERTAKER ADDRESS

SUPPLEMENTAL

Exact statement of OCCUPATION is very important.

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