

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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. See instructions on back of certificate.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Mississippi File No. _____
Registration District No. 569 Registered No. _____
Inc. Town _____ Primary Registration District No. 3765 **6373**

City _____ (No. _____ St., _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Everett Alonzo Raynor
(a) Residence. No. 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 43 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 widow
Widowed _____ or Divorced _____
(Write the word)

5a If married, widowed, or divorced HUSBAND of Maud Hardin Raynor
(or) WIFE of _____

6 DATE OF BIRTH Jan 1 1878
(Month) (Day) (Year)

7 AGE 53 yrs. 1 mos. 8 ds. IF LESS than 1 day _____ hrs. or _____ min?

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

9 BIRTHPLACE (city or town) Taylor Co Iowa
(State or country)

PARENTS
10 NAME OF FATHER Alfred Raynor
11 BIRTHPLACE OF FATHER (city or town) Derry Co Ohio
(State or country)
12 MAIDEN NAME OF MOTHER Alice Turner
13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 (Informant) Chas. A Raynor
(Address) Cairo Ill. 1325-25th St

15 Filed 2/10, 1931 Admushall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9 1931
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1930, to July 8, 1931, that I last saw him alive on July 8, 1931, and that death occurred on the date stated above at 4 m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
23A
(Duration) 1 yrs. _____ mos. _____ ds.

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

18 WHERE WAS DISEASE CONTRACTED
if not at place of death? Home

Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. C. Sullivan, M. D.
2/9, 1931. (Address) Wickliffe Ky

*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 OR REMOVAL Wickliffe County Ky DATE OF BURIAL 2-10 1931
20 UNDERTAKER W. H. Faulstich ADDRESS Wickliffe Ky

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

(a) *Foreman*, (b) *Auto-*
worked on may form
t. Never return "La-
" *Dealer*," etc., with-
as *Day laborer*, *Farm*
etc. Women at home,
of the household only

Keepers 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 years)*. 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 symptom 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, periton-eum*, 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 inter-stitial 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 symp-

omatic), "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