

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

10514

APR 24 1933

1. PLACE OF DEATH

7- County Madaway Registration District No. 629 File No. 337
 Township Jackson Primary Registration District No. 5831 Registered No. 17
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Charles Fremont Lyle

(a) Residence, No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 52 yrs. 9 mos. 00 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 9 29

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) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hankaster
 (STATE OR COUNTRY) P. Penn

10. NAME OF FATHER John Lyle

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

12. MAIDEN NAME OF MOTHER Susan Pierce

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

14. INFORMANT Eugene Lyle
 (Address) Maryville Mo

15. FILED 4/2 1933 A. P. Ross
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 31 1933

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1933, to Mar 31, 1933
 that I last saw him alive on Mar 31, 1933, and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstruction of the bowels

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY Bronchial Pneumonia
 (SECONDARY)

(duration) _____ yrs. _____ mos. 8 ds.

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?
 (Signed) Egbert Crowson, M. D.
 , 19 _____ (Address) Parnell 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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Parnell Mo. DATE OF BURIAL 4/2 1933

20. UNDERTAKER PricerFun. Co ADDRESS Maryville 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 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 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.; *Broncho-pneumonia* (secondary), 10ds. 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, septicaemia, 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison Registration District No. 624 File No. 337
Township Jackson Primary Registration District No. 5831 Registered No. 17
City (No. St. Ward)

2. FULL NAME

Charles Fremont Lyle
(a) Residence, No. St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 M (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 31 .1933

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

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5, 1856

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
76 9 29

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Obstruction of bowels Date of onset

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

unknown

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance:

Brucella pneumoniae

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

Name of operation 122 B Date of _____

13. NAME

What test confirmed diagnosis? _____ Was there an autopsy? _____

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

15. MAIDEN NAME

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury _____

17. INFORMANT (ADDRESS)

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL

24. Was disease or injury in any way related to occupation of deceased? _____

PLACE DATE 19____

If so, specify _____

19. UNDERTAKER (ADDRESS)

(Signed) _____, M. D.

20. FILED 19____ A P Ross Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

10514