

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.

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

PLACE OF DEATH
County Henry
Township _____ or _____
Village _____ or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 354 File No. 8975
Primary Registration District No. 424 Registered No. 11

FULL NAME Benjamin Waller Major

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>April 7 - 1825</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>11</u> mos. <u>1</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Good</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		
PARENTS	NAME OF FATHER <u>Weder Major</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>Nancy Head Overton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 9th, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 15, 1913, to March 9th, 1913, that I last saw him alive on March 9th, 1913, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Cystitis
137
135B (Duration) ___ yrs. ___ mos. ___ ds.
Contributory Enlarged Prostate
(SECONDARY) (Duration) 5 yrs. ___ mos. ___ ds.
(Signed) G. W. Head M. D.
3-8, 1913 (Address) Windsor Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robt E. Major
(ADDRESS) Windsor Mo
Filed Mar 9, 1913
REGISTRAR R. Remond

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 _____

PLACE OF BURIAL OR REMOVAL <u>Windsor Mo.</u>	DATE OF BURIAL <u>March 9</u> , 191 <u>3</u>
UNDERTAKER <u>W. C. Newton</u>	ADDRESS <u>Windsor Mo.</u>

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, 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 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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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PLACE OF DEATH

County Henry
 Township _____
 or
 Village _____
 or
 City Hindson (NO. _____) St. _____ Ward _____

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

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

Registration District No. 354 File No. _____
 Primary Registration District No. 4211 Registered No. 11

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

FULL NAME Reuben Walker Major

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>Apr. 7, 1825</u> (Month) (Day) (Year)		
AGE <u>87 yrs. 11 mos. 1 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Key, Mo.</u>		
PARENTS	NAME OF FATHER <u>Walter Major</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>Cecily Overton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/8, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3/5, 1913, to 3/8, 1913, that I last saw him alive on 3/8, 1913, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:
Cystitis

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

Contributory Enlarged Prostate
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. Veal M. D.
3-8, 1913 (Address) Hindson, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
 Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) Hindson, Mo.

Filed 3/9 1913
[Signature]
 REGISTRAR

PLACE OF BURIAL OR REMOVAL
Hindson, Mo.

DATE OF BURIAL
3/9, 1913

UNDERTAKER
[Signature]

ADDRESS
Hindson

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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