

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

38576

1 PLACE OF DEATH

County Ray
Township Knoxville
or
Village
or
City

Registration District No. 915

File No.

Primary Registration District No. 6236

Registered No. 14

(NO.) St. Ward)

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

2 FULL NAME H. C. Loyd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED W.
(Write the word)

16 DATE OF DEATH November 19, 1916
(Month) (Day) (Year)

6 DATE OF BIRTH Jan 7, 1840
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 17, 1916 to Nov. 19, 1916, that I last saw him alive on Nov. 15, 1916, and that death occurred, on the date stated above, at 5:00 P. M.

7 AGE 76 yrs. 10 mos. 12 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Apoplexy
Wife

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

(Duration) 1 yrs. 5 mos. 5 ds.

9 BIRTHPLACE (City or town, State or foreign country) Ray, Mo

CONTRIBUTORY (Secondary) Chr. Bronchitis + Cystitis
(Duration) 2 yrs. 1 mos. 1 ds.

10 NAME OF FATHER Thomas Loyd

(Signed) G. A. Lang M. D.
Nov. 20, 1916 (Address) Ray, Mo

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Geo

12 MAIDEN NAME OF MOTHER Talsa Chatman

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ray, Mo

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

18 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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Loyd

(Address) Rayville, Mo

19 PLACE OF BURIAL OR REMOVAL Peegarden Cem DATE OF BURIAL Nov 20 1916

Filed Nov. 20, 1916 Dr. W. G. Gaines Registrar

20 UNDERTAKER J. B. Broadhurst ADDRESS Rayville, Mo

Revised United States Standard Certificate of Death

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

6 **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.)

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

1 PLACE OF DEATH

County Ray Registration District No. 915 File No. _____
 or Ray Primary Registration District No. 6236 Registered No. 14
 Village _____ City _____ (NO. _____ St. _____ Ward _____)

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

2 FULL NAME David Crockett Loyd

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
 10 NAME OF FATHER _____
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
 12 MAIDEN NAME OF MOTHER _____
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Significant) William H. Loyd (Address) Rayville Mo.

15 Nov. 20, 1916 D. G. W. Gainer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 19 1916
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 1916 to _____ 1916 that I last saw h. _____ alive on _____ 1916 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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

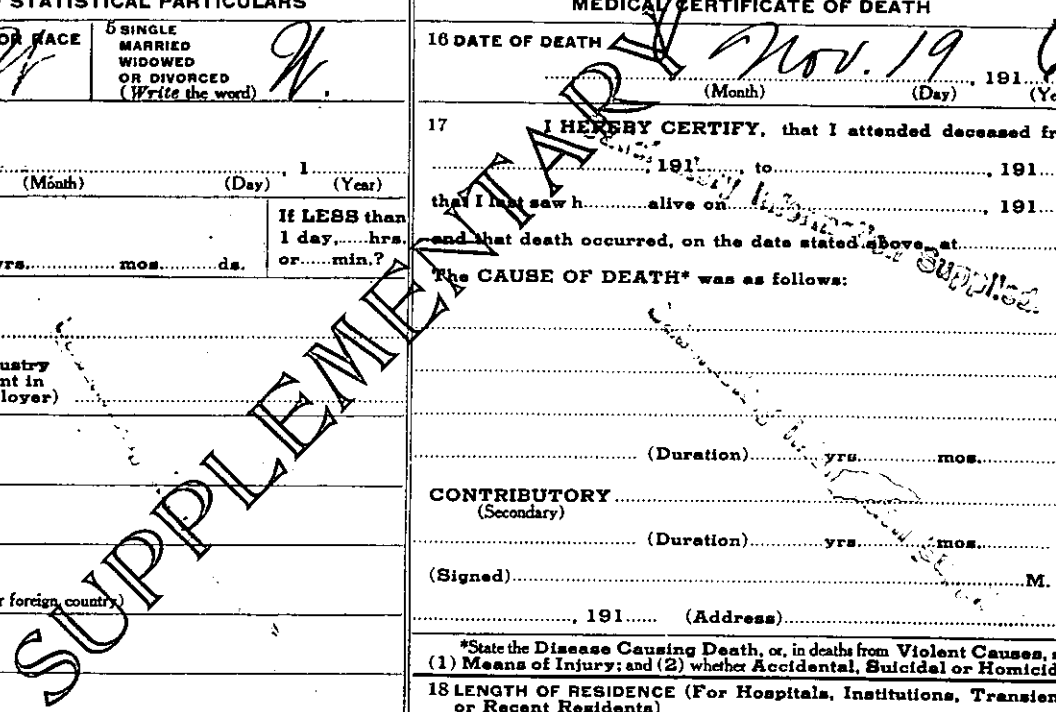
CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 1916 (Address) _____

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

18 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 _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1916

20 UNDERTAKER _____ ADDRESS _____



No. _____ 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.

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

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Tuberculosis of lungs, meninges, peritonaeum, 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), *29ds.*; *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.)