

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.

PLACE OF DEATH

County Madison
 Township Marquand
 or Marquand
 Village Marquand
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 539 File No. 40008
 Primary Registration District No. 4320 Registered No. _____

FULL NAME

Mrs Martha Cotner

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (If write the word)
DATE OF BIRTH <u>Probably about 1842</u> (Month) _____ (Day) _____ (Year) _____		
AGE <u>About 71</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeping</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Madison Co, Mo.</u>		
PARENTS	NAME OF FATHER <u>Daniel Whitener</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>North Carolina</u>	
	MAIDEN NAME OF MOTHER <u>Peggie Bees</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Johnson
 (ADDRESS) Buckhorn Mo.

Filed Dec 3 1913 J. W. Gale
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 3, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 30, 1913, to Dec 3, 1913,
 that I last saw her alive on Dec 3, 1913,
 and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

81A
95B Paralysis
 (Duration) 4 yrs. _____ mos. _____ ds.

Contributory Heart trouble
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. M. Carr M. D.
Dec 3, 1913 (Address) Marquand 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 State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Buckhorn Mo. DATE OF BURIAL Dec 4, 1913.

UNDERTAKER White Co ADDRESS Marquand 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*, *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 septicæmia," "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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS	
County <u>Madison</u>			CERTIFICATE OF DEATH	
Township or Village or City	<u>Marquand</u>		Registration District No. <u>539</u>	File No. _____
			Primary Registration District No. <u>4320</u>	Registered No. _____
FULL NAME <u>Mrs. Martha Cotner</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number)	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>F</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>Dec. 3, 1913</u> (Month) (Day) (Year)	
DATE OF BIRTH _____ (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above. The CAUSE OF DEATH* was as follows: <u>Paralysis Acute</u> <u>Heart Trouble</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Wm. H. Barr</u> M. D. <u>12/13/1913</u> (Address) <u>Marquand</u>	
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.				
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			*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 State _____ yrs. _____ mos. _____ ds. Where was disease contracted If not at place of death? _____ Former or usual residence _____	
BIRTHPLACE (City or town, State or foreign country) _____				
PARENTS	NAME OF FATHER _____			
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____			
PARENTS	MAIDEN NAME OF MOTHER _____			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____ Filed _____ 191____ REGISTRAR <u>X G. W. Gale</u>			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____ UNDERTAKER _____ ADDRESS _____	

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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