

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 Supervisors
Township Cherryland Registration District No. 472 File No. 1752
or
Village _____ Primary Registration District No. 5636 Registered No. _____
or
City _____ (No. _____ St. _____ Ward _____)

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

FULL NAME Nancy E. Green

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Widow</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>July</u> <u>16</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Feb</u> <u>14</u> , 18 <u>40</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Nov 27</u> , 191 <u>2</u> , to <u>Jan 14</u> , 191 <u>2</u> , that I last saw her alive on <u>July 16</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>9 a.</u> m. The CAUSE OF DEATH* was as follows: <u>92 A</u> <u>106 B</u> <u>56 B</u>	
AGE <u>70</u> yrs. <u>11</u> mos. <u>3</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?			(Duration) ___ yrs. ___ mos. ___ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeping</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>— 9-0</u>			Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds. (Signed) _____ M. D. _____, 191____ (Address)	
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Samuel Gooset</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER <u>John Reynolds</u>		PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL <u>July 17</u> , 191 <u>2</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		UNDERTAKER <u>R. C. Spencer</u> ADDRESS <u>Sanford Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wesley Mc Green</u> (ADDRESS) <u>Bluffs city Mo</u> Filed <u>Jan 26</u> , 191 <u>2</u> <u>Mc Kie</u> REGISTRAR				

Revised United States Standard Certificate of Death

[Approved by U. S. Censur 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*, *peritonacum*, etc., *Carcinoma*, *Sar-*

coma, 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.)



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

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PLACE OF DEATH

County Lawrence
 Township X
 or
 Village X
 or
 City _____ (NO. _____ St.; _____ Ward)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 472 File No. 1752
 Primary Registration District No. X Registered No. _____

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

FULL NAME Nancy E. Green

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F.</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>wid.</u>
DATE OF BIRTH <u>Feb 14, 1840</u> (Month) (Day) (Year)		
AGE <u>71 yrs. 11 mos. 3 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Pharmacist with</u> <u>first assistant Valerius</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>		
PARENTS	NAME OF FATHER <u>Samuel G. Giddet</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	MAIDEN NAME OF MOTHER <u>John Reynolds</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 16, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 29, 1911, to Jan 14, 1912, that I last saw deceased on Jan 10, 1912, and that death occurred, on the date stated above, at 3a m. The CAUSE OF DEATH* was as follows:
Pharmacist with
first assistant Valerius
 (Duration) 3 yrs. ___ mos. ___ ds.
 Contributory Bronchitis
 (SECONDARY) (Duration) 3 yrs. ___ mos. ___ ds.
 (Signed) W. Rice M. D.
Jan 20, 1912 (Address) Stotts city 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Wesley M. Green
 (ADDRESS) Stotts City Mo.

Filed Jan 20, 1912 W. Rice REGISTRAR

PLACE OF BURIAL OR REMOVAL
X East Hill Cem DATE OF BURIAL
Jan 17, 1912
 UNDERTAKER
A. N. G. Spence ADDRESS
Sarcaxia Mo.

JAN 4

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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coma, 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.)