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

1 PLACE OF DEATH
 County St. Francois
 Township St. Francois or Village Farlington Mo. City Farlington Mo. (NO. _____) (St. _____) (Ward _____)
 Registration District No. 773 File No. 191810321
 Primary Registration District No. 4464 Registered No. 30

2 FULL NAME Mathias Petrie

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

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>m</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OF, DIVORCED <u>W</u> (Write the word)
6 DATE OF BIRTH <u>Mar 3 1858</u> (Month) (Day) (Year)		
7 AGE <u>60 yrs. 0 mos. 18 ds.</u>		If LESS than 1 day, _____ hrs. or _____ min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Mississippi Co Mo.</u>		
PARENTS	10 NAME OF FATHER <u>Alexander Petrie</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scottland</u>	
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Shull</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>M. J. Petrie</u> (Address) <u>Farlington Mo.</u>		
15 Filed <u>Feb 22 1918</u> <u>A. J. Robinson</u> Registrar		

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>Mar 21 1918</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY, that I attended deceased from <u>Sept 15 1917</u> to <u>March 21 1918</u> that I last saw him alive on <u>March 19 1918</u> and that death occurred, on the date stated above, at <u>5 P. m.</u>	
The CAUSE OF DEATH* was as follows: <u>Phthisis Pulmonalis</u> <u>23</u> <u>28</u>	
(Duration) _____ yrs. _____ mos. _____ ds.	
CONTRIBUTORY (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>Dr. Frank B. Weber</u> M. D. <u>Feb 22 1918</u> (Address) <u>Farlington 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.	
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 <u>Woodmen Cemetery</u>	DATE OF BURIAL <u>Feb 23 1918</u>
20 UNDERTAKER <u>A. Neudert & Son</u>	ADDRESS <u>Farlington 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, 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; 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.)

1 PLACE OF DEATH

County

Francisco

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Township

Registration District No.

173

File No.

Village

Primary Registration District No.

4464

Registered No.

30

City

Emmington, Md

(NO.)

St. Ward)

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

2 FULL NAME

Mathias Petrie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M	4 COLOR OR RACE W	5 SINGLE MARRIED WIDOWED OR DIVORCED MARRIED
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6 DATE OF BIRTH

(Month) (Day) 1 (Year)

7 AGE

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)

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 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

May 16, 1918

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 21, 1918

17

I HEREBY CERTIFY, that I attended deceased from

that I last saw h. alive

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY

(Secondary)

(Signed) M. D.

1918 (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

20 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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