

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

24185
24175

PLACE OF DEATH
County Cape Girardeau
Township Cape Girardeau Registration District No. 125 File No. 24175
or
Village _____ Primary Registration District No. 3009 Registered No. 1225
or
City Cape Girardeau St.: _____ Ward _____
FULL NAME Eliza Jane McKee (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH Dec 27 1884
(Month) (Day) (Year)
AGE 13 9 18 IF LESS than
yrs. mos. ds. 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Pocahontas Mo.

PARENTS
NAME OF FATHER John Shemphry
BIRTHPLACE OF FATHER North Carolina
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Smith
BIRTHPLACE OF MOTHER Egypt, Illinois
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. McKee
(ADDRESS) Jackson Mo.
Filed Aug 15 1915 R. W. Fissell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 14 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 13, 1915, to Aug 14, 1915, that I last saw her alive on Aug 14, 1915, and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia
108
(Duration) _____ yrs. _____ mos. 8 ds.

Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) T. R. Williams M. D.
(Address) Cape Girardeau 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 Relby Ldg Mo. DATE OF BURIAL Aug 16 1915
UNDERTAKER Walker Turnall Co ADDRESS Cape Gir Mo

PLACE OF DEATH

County _____
 or
 Township _____
 or
 Village _____
 or
 City _____ (No. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
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 (for employer) _____

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

NAME OF FATHER _____
 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
 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 _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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, at _____
 The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.

Contributory (SECONDARY) _____
 *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 _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

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

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

1 PLACE OF DEATH *Cape Girardeau*
 County *Cape Girardeau* REGISTRARS SHALL NOT RECEIVE FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW
 Township *Cape Girardeau* Registration District No. *125* File No. _____
 or _____
 Village _____ Primary Registration District No. *3009* Registered No. *1225*
 or _____
 City _____ (No. _____) St. _____ Ward _____

2 FULL NAME *Cliza Jane McKee*

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
Satisfactory Information Supplied.

7 AGE _____ yrs. _____ mos. _____ ds.
 IF LESS than 1 day, hrs. or min.?
Satisfactory Information Supplied.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employee) _____
Satisfactory Information Supplied.

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 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____
 (Address) _____
Satisfactory Information Supplied.

15 Filed *Sept 27* 1915 *P. McNeill* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ (Month) _____ (Day) _____ (Year)
Aug 14 1915

17 I HEREBY CERTIFY, that I attended deceased from _____ 191_____ to _____ 191_____, that I last saw h. _____ 191_____, and that death occurred, on the date stated above, at _____ (m. The CAUSE OF DEATH* was as follows:
Satisfactory Information Supplied.
Pneumonia
Labar
 (Duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) *P. McNeill* Aug. 15 1915 (Address) *Cape Gir, 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) _____ Satisfactory Information Supplied.
 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 _____ 191_____
 20 UNDERTAKER _____ ADDRESS _____

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);

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Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc. (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.)