

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**

PLACE OF DEATH  
County Franklin  
Township Prairie  
or  
Village ~~Maupin~~  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 301 File No. 23481  
Primary Registration District No. 3418 Registered No. 1

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

FULL NAME Florence Mabel Hawkins

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>September 16, 1909</u> (Month) (Day) (Year)		
AGE <u>10</u> yrs. <u>15</u> mos. <u>15</u> 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) _____		

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

PARENTS	NAME OF FATHER <u>Patrick M. Hawkins</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>
	MAIDEN NAME OF MOTHER <u>Minnie Shoults</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) P. M. Hawkins  
(ADDRESS) Maupin, Mo.

Filed Aug 5 1910 J. H. Theaker  
Deputy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Aug July 31, 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 21, 1910, to July 31, 1910, that I last saw her alive on July 31, 1910, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH was as follows:  
Syphilitic

Contributory \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. R. Harman M. D.  
Aug 1 1910 (Address) Luebbering 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 <u>Fairview Cemetery</u>	DATE OF BURIAL <u>Aug 1st 1910</u>
UNDERTAKER <u>The Family</u>	ADDRESS <u>Maupin 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

will be sufficient, e. g., *Farmer* or *Planter*, *Compositor*, *Architect*, *Locomotive engineer*, *Stationary fireman*, etc. But in many industrial employments, it is necessary (a) the kind of work and also (b) the business or industry, and therefore an is provided for the latter statement; it only when needed. As examples: (a) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (b) *Automobile factory*. The material form part of the second statement. "Laborer," "Foreman," "Manager," without more precise specification, as *farm laborer*, *Laborer—Coal mine*, etc. who are engaged in the duties of the (not paid *Housekeepers* who receive a may be entered as *Housewife*, *Housewife*, and children, not gainfully employed, *At home*. Care should be taken to re- the occupations of persons engaged in e for wages, as *Servant*, *Cook*, *House- he occupation has been changed or given of the DISEASE CAUSING DEATH, state oc- inning of illness. If retired from busi- may be indicated thus: *Farmer (re- For persons who have no occupation ; None.**

**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*, *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.)

