

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

PLACE OF DEATH

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

Registration District No. 316 File No. 23509
Primary Registration District No. 3435 Registered No. 12

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

FULL NAME Edna Irene Green

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>Aug</u> (Month) <u>25</u> (Day) <u>1910</u> (Year)		
AGE <u>7</u> yrs. <u>25</u> mos. <u>25</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) Ash Grove Mo

PARENTS	NAME OF FATHER <u>J E Green</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St Clair Co Mo</u>
	MAIDEN NAME OF MOTHER <u>Nellie Loyde</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Carthage Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Green
(ADDRESS) Ash Grove Mo

Filed Aug 16 1910 Paul Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Aug (Month) 15 (Day) 1910 (Year)
I HEREBY CERTIFY, that I attended deceased from one July 20, 1910, to July 21, 1910, that I last saw him alive on July 21, 1910, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Pneumonia Bith
159
1180 (Duration) ___ yrs. ___ mos. 25 ds.

Contributory Infection (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J C Miller M. D.
Aug 15 1910 (Address) _____

*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. 25 ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence Ash Grove Mo

PLACE OF BURIAL OR REMOVAL <u>Walnut Grove</u>	DATE OF BURIAL <u>Aug 16</u> 1910
UNDERTAKER <u>J. F. Koberger</u>	ADDRESS <u>Ash Grove Mo</u>

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.

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*, *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.)



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

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

PLACE OF DEATH
County Green
Township Boone or Village _____
City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 316 File No. 23509
Primary Registration District No. 5435 Registered No. _____

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

FULL NAME Edna Irene Green

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>Aug 15</u> , 191 <u>1</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>X Aug 20</u> , 19 <u>10</u> (Month) (Day) (Year)			I HEREBY CERTIFY that I attended deceased from <u>Aug 20</u> , 191 <u>0</u> , to <u>Aug 21</u> , 191 <u>0</u> , that I last saw her alive on <u>Aug 21</u> , 191 <u>0</u> , and that death occurred, on the date stated above, at <u>X</u> m.	
AGE <u>25</u> yrs. <u>25</u> mos. <u>25</u> ds.			The CAUSE OF DEATH* was as follows: <u>Premature birth</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory <u>Indigestion</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Pish Grove, Mo.</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>J. E. Green</u>		(Signed) <u>J. E. Miller</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St. Clair Co. Mo.</u>		(Address) <u>Pish Grove</u>	
	MAIDEN NAME OF MOTHER <u>Stellie Loyds</u>		*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Carthage, Mo.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. E. Green</u> (ADDRESS) <u>Ashville, Mo.</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>Aug 16</u> , 191 <u>1</u> <u>R. S. Smith</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Walnut Grove</u>	
Original file date <u>X</u> _____, 19____			DATE OF BURIAL <u>Aug 16</u> , 191 <u>0</u>	
			UNDERTAKER <u>J. F. Knobsinger, Ash Grove, Mo.</u>	
			ADDRESS <u>Ash Grove, Mo.</u>	

SUPPLEMENTARY

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.)