

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

PLACE OF DEATH  
County Wright

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or Mountain Grove  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 908

File No. 36772

Primary Registration District No. 4549

Registered No. 50

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

FULL NAME Mary Koontz

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

DATE OF DEATH Nov 16, 1910  
(Month) (Day) (Year)

DATE OF BIRTH April 10, 1847  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 12<sup>th</sup>, 1910, to Nov 16, 1910, that I last saw her alive on Nov 16, 1910, and that death occurred, on the date stated above, at 9:50 a.m.

AGE 63 yrs. 7 mos. 6 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

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

132A Bright's Disease

BIRTHPLACE (City or town, State or foreign country) Galesburg, Ill.

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

PARENTS NAME OF FATHER Paschal Bandy BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky MAIDEN NAME OF MOTHER Lovica Holloway BIRTHPLACE OF MOTHER (City or town, State or foreign country)

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. G. Clark

(Signed) Dr. R. E. B. C. Rauer M. D. Nov 17, 1910 (Address) Mountain Grove Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(ADDRESS) Mountain Grove Mo

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Filed Nov 18, 1910 A. G. Clark REGISTRAR

Where was disease contracted if not at place of death? Former or usual residence

PLACE OF BURIAL OR REMOVAL Spokane DATE OF BURIAL Nov 19, 1910

UNDERTAKER A. G. Clark ADDRESS Mountain Grove Mo

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*, *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*, *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.)

HUGH STEPHENS, JEFFERSON CITY.



CAUSE OF DEATH... STATEMENT... INFORMATION is very important.

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PLACE OF DEATH

County Wright  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Mountain Grove (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 908 File No. 36772  
Primary Registration District No. 4549 Registered No. 50

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

FULL NAME Mary Koontz

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married  
(If r/s the word)

DATE OF DEATH Nov. 16, 1910  
(Month) (Day) (Year)

DATE OF BIRTH April 10, 1847  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 12, 1910, to Nov. 16, 1910, that I last saw live on Nov. 16, 1910, and that death occurred, on the date stated above, at 9:30 m.

AGE 63 yrs. 7 mos. 6 ds. If LESS than 1 day, .... hrs. or .... min.?

The CAUSE OF DEATH\* was as follows:

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

Bright Disease  
\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Galesburg Ill

PARENTS NAME OF FATHER Pascal B. Boy BIRTHPLACE OF FATHER (City or town, State or foreign country) Madison Ky MAIDEN NAME OF MOTHER Louise Galloway BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) R. P. Resler M. D. (Address) Mountain Grove, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) N. G. Clark (ADDRESS) Mountain Grove 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 \_\_\_\_\_

FILE NO. 36772 1910 Dr. E. Butcher REGISTRAR

PLACE OF BURIAL OR REMOVAL Spokane DATE OF BURIAL Nov 18, 1910  
UNDERTAKER N. G. Clark ADDRESS Mountain Grove

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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