

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 Cass
Township Wayton Registration District No. 161 File No. 37349
or Wayton Primary Registration District No. 5226 Registered No. 6
Village _____
or _____
City _____ (NO. _____) St. _____ Ward _____

FULL NAME Evangeline Williams

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>November 13, 1910</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>September 24, 1884</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Nov 8, 1910</u> , to <u>Nov 13, 1910</u> , that I last saw her alive on <u>Nov 13, 1910</u> , and that death occurred, on the date stated above, at <u>7 P.</u> m.	
AGE <u>26</u> yrs. <u>2</u> mos. <u>19</u> ds.			The CAUSE OF DEATH* was as follows: <u>Tuberculosis of both lungs</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) <u>Not known</u> yrs. mos. ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Polina Mo</u>			Contributory (SECONDARY) (Duration) _____ yrs. mos. ds.	
PARENTS	NAME OF FATHER <u>John Goodpasture</u>	(Signed) <u>E. S. Saddy</u> M. D.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>	<u>Dec 10, 1910</u> (Address) <u>Garden City Mo</u>		
	MAIDEN NAME OF MOTHER <u>Eling Wilson</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>Lesterville 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) _____ (ADDRESS) _____			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>Dec 1, 1910</u> <u>H. C. S. Klodd</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Wayton Cemetery</u> DATE OF BURIAL <u>Nov 14, 1910</u>	
			UNDERTAKER <u>Jesse Kaufman</u> ADDRESS <u>Garden City 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*, *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.)



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

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

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

Registration District No. 161
 Primary Registration District No. 52216

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

File No. 37349
 Registered No. 6

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

FULL NAME Euangelina Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Sept. 24, 1884
 (Month) (Day) (Year)

AGE 26 yrs. 2 mos. 19 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
 NAME OF FATHER John Goodfixature
 BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis
 MAIDEN NAME OF MOTHER Eliza Wilson
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lebanonville, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Goodfixature
 (ADDRESS) Garden City, Mo. R#3

Filed Nov 20 1910 Dr. S. Dodd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 13, 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 8, 1910, to Nov. 13, 1910, that I last saw alive on Nov. 13, 1910, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Tuberculosis of both lungs.
 (Duration) Don't know yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
 (Signed) C. A. Dodd M. D. (Address) Garden City, Mo.
12/10, 1910

*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 Dayton Cemetery DATE OF BURIAL 11/14, 1910
 UNDERTAKER Cesec Kaufman ADDRESS Garden City, Mo.

Dec. 1 All information called for must be written on this Supplementary Certificate. Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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