

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 Macon
Township _____
or
Village _____
or
City Macon (NO. _____) St. _____ Ward _____

Registration District No. 588 File No. 38767
Primary Registration District No. 3077 Registered No. 790

FULL NAME Nancy Kerripen

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 14, 1864
(Month) (Day) (Year)

AGE 46 yrs. 1 mos. 19 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Itasca Ohio

PARENTS
NAME OF FATHER Jacob Traxel
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Kerripen
(ADDRESS) _____

Filed DEC 1 1910
E. P. Dorek
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 2, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from onset, 1910, to _____, 191____,
that I last saw her alive on Oct 1st, 1910,
and that death occurred, on the date stated above, at 59 m.

The CAUSE OF DEATH* was as follows:
Burns (accident)

Contributory none
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. L. Kerripen M. D.
Oct 2 1910 (Address) Macon 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 City Home
DATE OF BURIAL Oct 4, 1910
ADDRESS Macon

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*, *peritonaeum*, 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 diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis." State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or 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.)



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PLACE OF DEATH

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

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 5-33
Primary Registration District No. 3027

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
File No. 38767
Registered No. 7910

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

FULL NAME Nancy Crippen

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>L.M.</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Sept. 12, 1864</u> <small>(Month) (Day) (Year)</small>		
AGE <u>46 yrs. 1 mos. 19 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1910, to _____, 1910, that I last saw _____ alive on Oct. 1, 1910, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Burn (accident)
Burn

BIRTHPLACE (City or town, State or foreign country) Staca, Ohio

PARENTS

NAME OF FATHER <u>Jacob Trost</u>	(Duration) _____ yrs. _____ mos. _____ ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	(Signed) <u>M. A. Miller</u> M. D.
MAIDEN NAME OF MOTHER <u>Wm. Brown</u>	<u>Oct. 2</u> , 191 <u>0</u> (Address) <u>Macau, Mo.</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>11</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Contributory none
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Crippen
(ADDRESS) Macau Mo

Filed Dec 1 1910 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>City Cemetery</u>	DATE OF BURIAL <u>Oct. 4</u> , 191 <u>0</u>
UNDERTAKER <u>W. H. Stone</u>	ADDRESS <u>Macau</u>

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

File date Dec. 1

Revised United States Standard Certificate of Death

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

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