

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.

PLACE OF DEATH

MISSOURI STATE BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County Oregon  
 Township Woodburn or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 Registration District No. 636 File No. 39041  
 Primary Registration District No. 5843 Registered No. 15

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

FULL NAME Maggie Shipworth

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married  
 DATE OF BIRTH Aug 24<sup>th</sup>, 1880  
 AGE 30 yrs. 1 mos. 24 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

DATE OF DEATH Oct 17<sup>th</sup>, 1910  
 (Month) (Day) (Year)

OCCUPATION (a) Trade, profession, or particular kind of work House work  
 (b) General nature of industry, business, or establishment in which employed (or employer) 212 1/2 212 M

I HEREBY CERTIFY, that I attended deceased from Oct 17, 1910, to Oct 17, 1910, that I last saw her alive on Oct 17, 1910, and that death occurred, on the date stated above, at 7 P m.  
 The CAUSE OF DEATH\* was as follows:

BIRTHPLACE (City or town, State or foreign country) nebo ky

Full out of wagon and bath wheels run over her producing internal injuries  
 (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

PARENTS NAME OF FATHER David Teague  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) nebo. ky  
 MAIDEN NAME OF MOTHER S E Bryant  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cashersburg ky

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
 (Signed) J. P. Mclellan M. D. 10/20, 1910 (Address) allow mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) David Teague

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

(ADDRESS) RFD Cotton Mo

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 \_\_\_\_\_

Filed 12/15, 1910, J. P. Mclellan REGISTRAR

PLACE OF BURIAL OR REMOVAL D. Vance Cemetery DATE OF BURIAL Oct 18, 1910  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# 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 health of various pursuits can be known. The question applies to each and every person, irrespective of or many occupations a single word or term on line will be sufficient, e. g., *Farmer* or *Planter*, *m*, *Composer*, *Architect*, *Locomotive engineer*, *ingineer*, *Stationary fireman*, etc. But in many specially in industrial employments, it is necessary to know (a) the kind of work and also (b) the of the business or industry, and therefore an additional line is provided for the latter statement; it to be used only when needed. As examples: (a) *erman*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; *erman*, (b) *Automobile factory*. The material on may form part of the second statement. return "Laborer," "Foreman," "Manager," " etc., without more precise specification, as *orer*, *Farm laborer*, *Laborer—Coal mine*, etc. at home, who are engaged in the duties of the old only (not paid *Housekeepers* who receive a salary), may be entered as *Housewife*, *House- At home*, and children, not gainfully employed, *hool* or *At home*. Care should be taken to re- cifically the occupations of persons engaged in : service for wages, as *Servant*, *Cook*, *House-*  
If the occupation has been changed or given account of the DISEASE CAUSING DEATH, state oc- at beginning of illness. If retired from busi- it fact may be indicated thus: *Farmer (re- tired, 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.)



WITH UN-... THIS IS A SUPPLEMENTARY 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.

PLACE OF DEATH

County Oregon  
Township Woodside  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

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.  
Registration District No. 636 File No. 39041  
Primary Registration District No. 5843 Registered No. 15-

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>married</u>
DATE OF BIRTH <u>Aug 4, 1880</u> (Month) (Day) (Year)		
AGE <u>30</u> yrs. <u>1</u> mos. <u>24</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Nevs Ky</u>		
PARENTS	NAME OF FATHER <u>David League</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Nevs Ky</u>	
	MAIDEN NAME OF MOTHER <u>S. E. Bryant</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ashleyburg Ky</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Oct 17, 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 17, 1910, to Oct 17, 1910, that I last saw him alive on Oct 17, 1910, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH\* was as follows:  
Fell out of wagon and both wheels ran over her producing internal injuries.

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

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

(Signed) I. L. Palen M. D.  
(Address) Alton 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) David League  
(ADDRESS) R. F. D. Alton Mo  
Filed 12/15 1910 J. P. McCallister REGISTRAR  
I. L. Palen

PLACE OF BURIAL OR REMOVAL  
J. D. Lane Cemetery  
DATE OF BURIAL  
Oct 18, 1910  
UNDERTAKER  
Wm. Staires ADDRESS  
Alton Mo

DEC

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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**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 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.)