

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 Pitts

Township Leath Creek

Village _____

City _____

Registration District No. 673

Primary Registration District No. 5896

CERTIFICATE OF DEATH

File No. 39151

Registered No. 10

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

FULL NAME

Julia Rose Kabler

PERSONAL AND STATISTICAL PARTICULARS

SEX

girl

COLOR OR RACE

white

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

+

DATE OF BIRTH

June 21, 1910
(Month) (Day) (Year)

AGE

5½ yrs. 5½ mos. 5½ ds.
If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

—

BIRTHPLACE

(City or town, State or foreign country)

Lookout mo

PARENTS

NAME OF FATHER

Carnest Kabler

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Pitts Co mo

MAIDEN NAME OF MOTHER

Rose Shaw

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Pitts Co mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Saml Kabler

(ADDRESS)

Beaman mo

Filed

Dec 7, 1910

J. E. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 6, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 2, 1910, to Dec 6, 1910, that I last saw her alive on Dec 6, 1910, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Infant's Paralysis

16

(Duration) ___ yrs. ___ mos. 16 ds.

Contributory

(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed)

J. E. Mitchell

M. D.

Dec 7, 1910 (Address) Beaman 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

Union cemetery

DATE OF BURIAL

Dec 7, 1910

UNDERTAKER

McLure Bros

ADDRESS

Sedalia mo

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.)



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 PittsTownship Hewth creek

or

Village _____

or

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 673

File No. _____

Primary Registration District No. 589ERegistered No. 10

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

FULL NAME Julia Rose Kabler

PERSONAL AND STATISTICAL PARTICULARS

SEX

girl

COLOR OR RACE

white

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

June 21, 1910
(Month) (Day) (Year)

AGE

5½ yrs. 5 mos. — ds.

If LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) Lookout mo

PARENTS

NAME OF FATHER

Ernest Kabler

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Pitts Co

MAIDEN NAME OF MOTHER

Rose Shaw

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Pitts Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jan Kabler(ADDRESS) Beaman moFiled Dec 10 1910

1910

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 6, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 21, 1910, to Dec 6, 1910, that I last saw her alive on Dec 6, 1910, and that death occurred, on the date stated above, at 8:40 a.m. The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) _____ yrs. _____ mos. 16 ds.

Contributory _____

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Mitchell

M. D.

Beaman mo, 1910 (Address) Beaman 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

Union cemetery

DATE OF BURIAL

Dec 8, 1910

UNDERTAKER

McLaughlin Bros

ADDRESS

Beaman mo

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.)

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