

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 Repley  
Township Shickus  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 751 File No. 39327

Primary Registration District No. 5990 Registered No. 44

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

**FULL NAME** Martha McCarty

**PERSONAL AND STATISTICAL PARTICULARS**

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

**DATE OF BIRTH** Don't know  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

**AGE** Don't know If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

**BIRTHPLACE**  
(City or town, State or foreign country) Indiana

**PARENTS**  
**NAME OF FATHER** Bill Main

**BIRTHPLACE OF FATHER**  
(City or town, State or foreign country) Ind.

**MAIDEN NAME OF MOTHER** Don't know

**BIRTHPLACE OF MOTHER**  
(City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Albert McCarty

(ADDRESS) \_\_\_\_\_

Filed 12-9 1910 W. D. Bennis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH** Dec 9th, 1910  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from Dec 8th, 1910, to Dec 9th, 1910, that I last saw her alive on Dec 8th, 1910, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Eclampsia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. one ds.

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

(Signed) R. C. Lyon M. D.  
12/9 1910 (Address) Waylor 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** Kelsoy Cemetery **DATE OF BURIAL** 12-10, 1910

**UNDERTAKER** Geo Green **ADDRESS** Waylor

# 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.)



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MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Ripley  
Township Thomas  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 751  
Primary Registration District No. 5990

File No. 39329  
Registered No. 44

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

FULL NAME Martha McLearty

PERSONAL AND STATISTICAL PARTICULARS

SEX ♀ COLOR OR RACE W  
~~SINGLE~~  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
~~(Write the word)~~

DATE OF BIRTH Don't know  
(Month) (Day) (Year)

AGE Don't know  
If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?  
\_\_\_\_ mos. \_\_\_\_ ds.

OCCUPATION  
(a) Trade, profession, or particular kind of work Housekeeper  
(b) General nature of industry, business, or establishment which employed (or employed) Am. Houseworn

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

PARENTS  
NAME OF FATHER Bill Main  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.  
MAIDEN NAME OF MOTHER Don't know  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Albert McLearty

(ADDRESS) Kaylor

Filed 12-30 1910 W. T. Bernier REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12-7- 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12-8- 1910, to 12-9- 1910, that I last saw her alive on 12-8- 1910, and that death occurred, on the date stated above, at \_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

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

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) R. B. Lyon M. D.  
12/9 1910 (Address) Naylor, 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 Kelsey Cem- DATE OF BURIAL 12-10- 1910

UNDERTAKER G. S. Green ADDRESS Naylor

DEC

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

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