

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

PLACE OF DEATH

County Washington
Township Kingston
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 889 File No. 40842
Primary Registration District No. 6187 Registered No. 6 18

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

FULL NAME Julia Annie Pratt

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH June 21, 1903
(Month) (Day) (Year)

AGE 7 yrs. 5 mos. 7 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Kingston township

PARENTS
NAME OF FATHER Columbus Pratt
BIRTHPLACE OF FATHER (City or town, State or foreign country) Bruis mo
MAIDEN NAME OF MOTHER Marydaisy Bayer
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bruis

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Deak Pruitte

(ADDRESS) _____

Filed Dec 31, 1910 E. J. Ryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 9, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 26, 1910, to Dec 9, 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:

1 Typhoid Fever
36
(Duration) ___ yrs. ___ mos. 20 ds.

Contributory Pyæmia
(SECONDARY) (Duration) ___ yrs. ___ mos. 6 ds.
(Signed) David Ford M. D.
Dec 9, 1910 (Address) Brehwood 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? CT
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Old Minet DATE OF BURIAL Dec 10, 1910

UNDERTAKER _____ ADDRESS _____

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.

WHILE TRAVELING WITH UNFADING INK. LEGALS & PERMANENT RECORD

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

PLACE OF DEATH

County.....
 Township..... Registration District No. File No.
 or Village..... Primary Registration District No. Registered No.
 or City.....(NO.) St.:.....Ward) ..
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX.....
 COLOR OR RACE.....
 SINGLE MARRIED WIDOWED OR DIVORCED (If *rite* the word)
 DATE OF BIRTH.....(Month).....(Day).....(Year)
 AGE.....yrs.....mos.....ds. IF LESS than 1 day.....hrs. or.....min.?

OCCUPATION.....
 (a) Trade, profession, or business, or establishment in which employed (or employer)
 (b) General nature of industry, business, or establishment in which employed (or employer)

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

NAME OF FATHER.....

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

MAIDEN NAME OF MOTHER.....

BIRTHPLACE OF MOTHER.....
 (City or town, State or foreign country)

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

(ADDRESS).....

Filed....., 191....., REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH.....(Month).....(Day).....(Year)
 I HEREBY CERTIFY, that I attended deceased from....., 191....., to....., 191....., that I last saw h.....alive on....., 191..... and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:
(Duration).....yrs.....mos.....ds.
(Duration).....yrs.....mos.....ds.
 (Signed)....., 191.....(Address)..... M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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. State.....yrs.....mos.....ds.
 Where was disease contracted if not at place of death?
 Former or usual residence.....

PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL....., 191.....

UNDERTAKER..... ADDRESS.....

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

County Washington
 Township Kingston
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 889 File No. 40842
 Primary Registration District No. 6187 Registered No. 6 18

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

FULL NAME Julia Annie Pratt

PERSONAL AND STATISTICAL PARTICULARS

BEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>June 21, 1903</u> (Month) (Day) (Year)		
AGE <u>7</u> yrs. <u>5</u> mos. <u>7</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>m</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Dec 9, 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 26, 1910, to Dec 9, 1910, that I last saw him 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:
Pythoid fever

BIRTHPLACE (City or town, State or foreign country) Kingston Township, Ind. (Duration) _____ yrs. _____ mos. 20 ds.

PARENTS

NAME OF FATHER <u>Columbus Pratt</u>	CONTRIBUTORY (SECONDARY) <u>Pyæmia</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Greene Mo</u>	(Signed) <u>David Ford</u> M. D. <u>Dec 9, 1910</u> (Address) <u>Rushworth Mo</u>
MAIDEN NAME OF MOTHER <u>Mr. George Boyer</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>Greene</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) Mr. Deeds Pratt
 (ADDRESS) Kingston Mo

PLACE OF BURIAL OR REMOVAL
Oed Mines

DATE OF BURIAL
Dec 10, 1910

UNDERTAKER
none

ADDRESS _____

Filed Dec 9, 1910 at Kingston, Mo
G. S. [Signature] REGISTRAR

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]

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 septichaemia," "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.)