

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 Harrison ~~191~~  
Township Fox Creek  
or  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 334 File No. 1251  
Primary Registration District No. 5468 Registered No. \_\_\_\_\_

FULL NAME Elisabeth Chambers (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 (Write the word) <u>Widow</u>
DATE OF BIRTH <u>June 12<sup>th</sup></u> , 18 <u>76</u> (Month) (Day) (Year)		
AGE <u>84</u> yrs. <u>6</u> mos. <u>11</u> ds.		if LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> 1866-1910		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u> 1910-1911		
BIRTHPLACE (City or town, State or foreign country) <u>Richmond Co, Ohio</u>		
PARENTS	NAME OF FATHER <u>John Stoner</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	
	MAIDEN NAME OF MOTHER <u>Rebecca Croy</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Jan. 2<sup>nd</sup>, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from November 19<sup>th</sup>, 1910, to Dec. 19<sup>th</sup>, 1910, that I last saw her alive on Dec. 17, 1910, and that death occurred, on the date stated above, at 7:48 p.m.

The CAUSE OF DEATH\* was as follows:  
Fracture Neck of Femur (Right)  
Duration: yrs. two mos. two ds.

Contributory (SECONDARY) Bronchopneumonia  
Duration: yrs. \_\_\_\_\_ mos. four ds.

Signed: Lizzie T. Webb, M. D.  
Jan 7<sup>th</sup>, 1911 (Address) Mt Moreau

\*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  
Sharon Cemetery

DATE OF BURIAL  
\_\_\_\_\_ 1911

UNDERTAKER  
S. Clappert

ADDRESS  
Mt Moreau, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) D. O. Wooderson  
(ADDRESS) Melbourne, Mo

Filed Jan 5, 1911 Jackson Hader  
REGISTRAR

# 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.)



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

PLACE OF DEATH  
 County Lancaster  
 Township Four Oaks  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 334 File No. 1757  
 Primary Registration District No. 3468 Registered No. \_\_\_\_\_

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

FULL NAME Elizabeth Chambers

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow  
 (If write the word)  
 DATE OF BIRTH Jan 22, 1886  
 (Month) (Day) (Year)  
 AGE 64 yrs. 6 mos. 11 ds.  
 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

DATE OF DEATH \_\_\_\_\_, 1911  
 (Month) 1-7 (Day) (Year)  
 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:

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

Fracture Neck of Femur - accidental  
 Stumbled and fell on a pile of wood in floor  
 Contributory Bronchial Pneumonia  
 (SECONDARY)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Lisle P. Webb M. D.  
Jan 3, 1911 (Address) Ms. Mariah

BIRTHPLACE (City or town, State or foreign country) Richland, Ohio  
 NAME OF FATHER John Smith  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
 MAIDEN NAME OF MOTHER Rebecca O'oy  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

\*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. 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) W. Woodman  
 (ADDRESS) Mellowne Gap

PLACE OF BURIAL OR REMOVAL Sharon Cemt DATE OF BURIAL Jan 5, 1911  
 UNDERTAKER S. C. Carpenter ADDRESS Bethany

Filed Jan 5, 1911 Jaquelin Walker REGISTRAR

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