

PLACE OF DEATH

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

2094

County Jackson
Township Post Oak
or
Village
or
City (NO. _____ St. _____ Ward _____)42
Registration District No. 430 File No. 2
Primary Registration District No. 5586 Registered No. 1

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

FULL NAME Susan Townsend

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)DATE OF DEATH Jan 27, 1911
(Month) (Day) (Year)DATE OF BIRTH Dec 9, 1862
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mar 17, 1910, to Jan 23, 1911, that I last saw her alive on Dec 7th, 1910, and that death occurred, on the date stated above, at 6 A.M.AGE 49 yrs. 1 mos. 18 ds. IF LESS than 1 day, ____ hrs. or ____ min.?The CAUSE OF DEATH* was as follows:
uterine cancer - hysterectomy
metastases to mesenteric
glands in 3 mo. after
operation
(Duration) ____ yrs. 10 mos. 12 ds.OCCUPATION (a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) g-oBIRTHPLACE (City or town, State or foreign country) Missouri

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

PARENTS NAME OF FATHER John RoseBIRTHPLACE OF FATHER (City or town, State or foreign country) PennMAIDEN NAME OF MOTHER Marie CronkBIRTHPLACE OF MOTHER (City or town, State or foreign country) State of Mo(Signed) Geo Anderson M. D.
Jan 25, 1911 (Address) Missouri Ave

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Anderson

(ADDRESS) _____

Filed Jan 27, 1911 Capra

REGISTRAR

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 Providence DATE OF BURIAL Jan 28th, 1911UNDERTAKER Ray Sheehey ADDRESS Lablone

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.)



PLACE OF DEATH

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

County Johnson
 Township Post Oak
 or
 Village _____
 or
 City _____

Registration District No. 430 File No. 2094
 Primary Registration District No. 55-86 Registered No. _____
 NO. _____ St. _____ Ward _____

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

FULL NAME

Susan Townsend

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED Married DIVORCED OR DIVORCED (Write the word)
 DATE OF BIRTH 12-9-1862
 (Month) (Day) (Year)
 AGE 49 yrs. 18 mos. 18 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS

NAME OF FATHER John R. Anderson
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Warrensburg Mo.
 MAIDEN NAME OF MOTHER Mary Ann
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) State of Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

John R. Anderson
Warrensburg Mo.

Filed

Jan 27 1911

REGISTRAR

City Clerk
Ray Linn

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3-15-1910, to 1-23-1911, that I last saw him alive on 12/7, 1911, and that death occurred, on the date stated above, at 6 a m. The CAUSE OF DEATH* was as follows:

Uterine Cancer - Hysterectomy
metastases to regional glands a 3 mos after operation
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

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

(Signed) Geo Anderson M. D.
1-27 1911 (Address) Warrensburg Mo.

*State the Disease Causing Death, or, in deaths from Violence 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

Sheloh Mo

DATE OF BURIAL

1-27 1911

UNDERTAKER

Ray Linn

ADDRESS

Sheloh

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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