

## PLACE OF DEATH

County PulaskiTownship Union

or

Village \_\_\_\_\_

or

City \_\_\_\_\_

(NO. \_\_\_\_\_)

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 711File No. 2 2965Primary Registration District No. 5440Registered No. 1

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Minnie Elizabeth Bartlett

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)Female white Married

DATE OF BIRTH

Sept 22 1843  
(Month) (Day) (Year)

AGE

17 4  
yrs. mos. 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)

g - (D)

BIRTHPLACE

(City or town, State or foreign country)

Tennessee

NAME OF FATHER

James Burnett

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

Melvinie Krause

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M E Bartlett(ADDRESS) 26 ixan MOFiled Jan 22 1911 M E Bartlett

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 20 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan. 16, 1911, to Jan. 20, 1911, that I last saw her alive on Jan. 20, 1911, and that death occurred, on the date stated above, at 3 p.m. The CAUSE OF DEATH\* was as follows:  
Influenza  
11B(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 4 ds.

Contributory

(SECONDARY)

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

(Signed)

✓

(Address)

✓

M. D.

\*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

DATE OF BURIAL

Pulaski Co. Pulaski MoJan 22 1911

UNDERTAKER

ADDRESS

George Zuyacki Prot CoSt. Louis

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.

# 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.)



ALL 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 Verlaska  
Township Union  
or  
Village  
or  
City

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

Registration District No. 711-

Primary Registration District No. 5946

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

File No. 2965

Registered No. 1

St.: Ward)

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

FULL NAME Minnie Elizabeth Bartlett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W- SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH 9-22-1843  
(Month) (Day) (Year)

AGE 67 yrs. 4 mos. 4 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) Conn.

DATE OF DEATH 1-20, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from  
1-16-1911, to 1-20-1911,  
that I last saw her alive on 1-20-1911,  
and that death occurred, on the date stated above, at 3 p.m.  
The CAUSE OF DEATH\* was as follows:

Angina pectoris  
(Duration) yrs. mos. ds. 4

Contributory  
(SECONDARY)  
(Duration) yrs. mos. ds.  
(Signed) Dr. McArthur M.D.  
1911 (Address) Dr. McArthur

\*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 Verlaska Bur. Parl. DATE OF BURIAL 1-22- 1911

UNDERTAKER Thompson Bros ADDRESS Dr. McArthur

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Bartlett

(ADDRESS) Dr. McArthur

Filed Jan 22 X 1911 X W. F. Bartlett X  
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]

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