

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

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

County Adair
Township Minnowah
or
Village _____
or
City _____ (No. _____ St.: _____ Ward)

28

Registration District No. 2 File No. 5077
Primary Registration District No. 5002N Registered No. _____

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

FULL NAME Kate Markes

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Oct 23, 1869
(Month) (Day) (Year)
AGE 41 yrs. 4 mos. — ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

BIRTHPLACE (City or town, State or foreign country) Adair Co. Mo.

PARENTS
NAME OF FATHER Andrew Scott
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Mary Jane Scott
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Larry Scott
(ADDRESS) Springer Mo
Filed _____ 1911 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 23, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1911, to Feb 23, 1911, that I last saw him alive on Feb 8, 1911, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:
Tuberculosis
23A
(Duration) Don't know yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) F. B. Farrington M. D.
Feb 23, 1911 (Address) Green Springs 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 Lick Ridge DATE OF BURIAL Feb 24, 1911
UNDERTAKER L. O. Young ADDRESS Green Springs Mo

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*, *Compositor*, *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.)



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

County Adair
Township Ninevah
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

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

CERTIFICATE OF DEATH
Registration District No. 2 File No. 5077
Primary Registration District No. 5002a Registered No. _____

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

FULL NAME Kate Marks

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Oct 23</u> , 18 <u>69</u> . <small>(Month) (Day) (Year)</small>		
AGE <u>41</u> yrs. <u>4</u> mos. <u>—</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Adair Co. Mo</u>		
PARENTS	NAME OF FATHER <u>Andrew Scott</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Mary Jane Scott</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. Scott</u> (ADDRESS) <u>Novinger Mo.</u>		
Filed <u>Feb 28</u> 19 <u>11</u> <u>L. O. Young</u> <u>J. L. Young</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Feb 23</u> , 19 <u>11</u> . <small>(Month) (Day) (Year)</small>	
I HEREBY CERTIFY, that I attended deceased from <u>Jan 1</u> , 19 <u>11</u> , to <u>Feb 23</u> , 19 <u>11</u> , that I last saw <u>alive</u> on <u>Feb 8</u> , 19 <u>11</u> , and that death occurred, on the date stated above, at <u>10 a.</u> m.	
The CAUSE OF DEATH* was as follows: <u>Tuberculosis</u>	
_____ (Duration) <u>Don't know</u> yrs. mos. ds.	
Contributory (SECONDARY) _____ (Duration) _____ yrs. mos. ds.	
(Signed) <u>L. B. Farrington</u> M. D. <u>Feb 23, 1911</u> (Address) <u>Green Top Mo</u>	
*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 <u>Lick Ridge</u>	DATE OF BURIAL <u>Feb. 24</u> , 19 <u>11</u>
UNDERTAKER <u>L. O. Young</u>	ADDRESS <u>Green Top Mo.</u>

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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