91

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

PLACE OF DEATH

County Lincoln

Township Union or Village ____ or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 490 File No. 6963

Primary Registration District No. 5653. Registered No. 4

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

FULL NAME Liza Ashby

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: Black

SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word): Married

DATE OF BIRTH: Jan (Month) 1 (Day), 1848 (Year)

AGE: 63 yrs. 1 mos. 7 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): 9-0

BIRTHPLACE (City or town, State or foreign country): Virginia

PARENTS

NAME OF FATHER: Harry Debose

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

MAIDEN NAME OF MOTHER: Vinia Debose

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Shedrick Turner his mark.

(ADDRESS) Eolia Mo.

Filed Feb. 9" 1911 O.K. Edgell Dept. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. (Month) 8" (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 4" 1911, to Feb. 8" 1911, that I last saw her alive on Feb. 8" 1911, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

10 7 H

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory (SECONDARY) 0

(Duration) ____ yrs. 0 mos. ____ ds.

(Signed) O.K. Edgell M. D.

Feb. 9" 1911 (Address) Eolia 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: Mt Eolia Cemetery Col

DATE OF BURIAL: Feb. 10 1911

UNDERTAKER: Goodloe Buchanan

ADDRESS: Eolia Mo

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, 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, peritonaeum,* etc., *Carcinoma, Sarcoma,* 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.)

HUGH STEPHENS, JEFFERSON CITY.

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

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

SUPPLEMENTARY

PLACE OF DEATH

County Lincoln

Township Union or Village ____ or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 490-

Primary Registration District No. 5653

File No. ____

Registered No. 4

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

FULL NAME Liza Ashby-

PERSONAL AND STATISTICAL PARTICULARS	
SEX	F
COLOR OR RACE	Black
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Married
DATE OF BIRTH	1-1-, 1848 (Month) (Day) (Year)
AGE	63 yrs. 1 mos. 7 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)	Va
NAME OF FATHER	Harry Debose-
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Va.
MAIDEN NAME OF MOTHER	Vinnia Debose
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Va -

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Shedrick Turner

(ADDRESS) Eolia Mo

Filed Feb. 9 1911 O. H. Dawson, R. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 - 8, 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-4-, 1911, to 2-8-, 1911, that I last saw her alive on 2-8, 1911, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

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

Contributory ____ (SECONDARY)

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

(Signed) O. K. Engle M. D.

2-9, 1911 (Address) Eolia, 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 Eolia Col. Cem.

DATE OF BURIAL 2-10-, 1911

UNDERTAKER Gooch & Buchanan

ADDRESS Eolia Mo.

Original file, date 2-9-, 1911 All information called for must be written on this Supplementary Certificate.

...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]

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