

CERTIFICATE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

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

PLACE OF DEATH

County Marion

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Hannibal

Registration District No. 154

547

File No. 7099

Primary Registration District No. 3029

Registered No. 3

(NO. Loving Hospital St. 6 Ward)

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

FULL NAME Julia Willis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

White

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

DATE OF DEATH

Feb 1

(Month) (Day) (Year)

DATE OF BIRTH

Dec 21, 1829

(Month) (Day) (Year)

AGE

82 yrs. 1 mos. 10 ds.

IF LESS than  
1 day, \_\_\_ hrs.  
or \_\_\_ min.?

I HEREBY CERTIFY, that I attended deceased from Dec 31, 1910, to Feb 1st, 1911, that I last saw her alive on Feb 1st, 1911, and that death occurred, on the date stated above, at 10 p.m. The CAUSE OF DEATH\* was as follows:

Senility

162

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

Contributory

(SECONDARY)

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

(Signed) Thos. Chorning

M. D.

1911 (Address)

\*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? At her home

Former or usual residence 211 Maple St. Hannibal Mo

PLACE OF BURIAL OR REMOVAL

Mount Olivet

DATE OF BURIAL

Feb 3, 1911

UNDERTAKER

Smith & Spalding Hannibal

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Hegariz

(ADDRESS) Hannibal

Filed Feb 2, 1911 : A. SCHEINEMAN 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*, *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.)



PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County Marion  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Stannibal (NO. Leveering Hospital 6 Ward)

Registration District No. 547 File No. 7099  
Primary Registration District No. 3029 Registered No. \_\_\_\_\_

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

FULL NAME Julia Willis

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)  
DATE OF BIRTH Dec. 21, 1829 (Month) (Day) (Year)  
AGE 82 yrs. 1 mos. 00 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Virginia  
PARENTS NAME OF FATHER William Willis BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia MAIDEN NAME OF MOTHER Sophie Snyder BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ed. De garris (ADDRESS) Stannibal Filed \_\_\_\_\_ (BY) \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb-1, 1911 (Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from Dec. 31, 1910, to Feb-1st, 1911, that I last saw her alive on Feb-1, 1911, and that death occurred, on the date stated above, at 6:30 P.M.  
The CAUSE OF DEATH\* was as follows:  
Senility  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Thomas Lehoung M. D. 2-2, 1911 (Address) Stannibal  
\*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? At her home  
Former or usual residence 2113 Maple Ave Stannibal Md

PLACE OF BURIAL OR REMOVAL Mount Olivet DATE OF BURIAL Feb-3, 1911  
UNDERTAKER Smith & Spalding ADDRESS Stannibal

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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