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

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

**PLACE OF DEATH**

County: Marion

Township: ____ or Village: ____ or City: Hannibal (NO. Levering Hospital 6 Ward)

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

64

Registration District No. 547 File No. 7104

Primary Registration District No. 3029 Registered No. 41

**FULL NAME** Sarah M. Moss

## PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH: June (Month) 24 (Day) 1847 (Year)

AGE: 64 yrs. ____ mos. 14 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): Housekeeping

BIRTHPLACE (City or town, State or foreign country): Bath Co Ky

PARENTS
NAME OF FATHER: John L. Richards
BIRTHPLACE OF FATHER (City or town, State or foreign country): Bath Co Ky
MAIDEN NAME OF MOTHER: Elizabeth Moore
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bath Co Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. T. Gill

(ADDRESS) Perry, Mo.

Filed Feb 9 1911 A. SCHEINEMAN, X REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 7 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from June 31, 1911, to Feb 7, 1911, that I last saw her alive on Feb 7, 1911, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
82A
82A

(Duration) ____ yrs. 3 mos. ____ ds.

Contributory (SECONDARY): Paralysis left side

(Duration) ____ yrs. 2 mos. 15 ds.

(Signed) Thos. Chowning M. D.

Feb 7, 1911 (Address) Hannibal 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. 8 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? Ralls Co Mo

Former or usual residence: Ralls Co Mo

PLACE OF BURIAL OR REMOVAL: Perry Mo

DATE OF BURIAL: Feb 9, 1911

UNDERTAKER: Smith & Spalding

ADDRESS: Hannibal, 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, 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

**PLACE OF DEATH**

County Marion

Township _____ or Village _____ or City Hannibal (NO. Levering Hospital St.: 6 Ward)

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

Registration District No. 547 File No. 7104

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 Sarah M. Moss

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Jan. 24 (Month) (Day), 1847 (Year)

AGE: 64 yrs. ___ mos. 14 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): Housekeeping

BIRTHPLACE (City or town, State or foreign country): Bath. Co. Kentucky

PARENTS
NAME OF FATHER: John L. Richards
BIRTHPLACE OF FATHER (City or town, State or foreign country): Bath Co. Ky.
MAIDEN NAME OF MOTHER: Elizabeth Moore
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bath Co. Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M. T. Gill

(ADDRESS) Perry Mo.

Filed Mch 29, 1911 A. Schiemeyer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Feb 7 (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 31, 1911, to Feb-7, 1911, that I last saw him alive on Feb-7, 1911, and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ___ yrs. 3 mos. ___ ds.

Contributory (SECONDARY) Paralysis left side

(Duration) ___ yrs. 2 mos. 15 ds.

(Signed) Thos. Chowning M. D.

Feb-7, 1911 (Address) Hannibal 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. 8 ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Ralls Co. Mo.

Former or usual residence Ralls Co. Mo.

PLACE OF BURIAL OR REMOVAL: Perry Mo.

DATE OF BURIAL: Feb-9, 1911

UNDERTAKER: Smith & Spalding

ADDRESS: Hannibal Mo

SUPPLEMENTARY

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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