

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

PLACE OF DEATH
County Dickson
Township Sherman
or
Village
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 257 File No. 13909
Primary Registration District No. 536 Registered No. ✓

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

FULL NAME Mary Jane Legarden

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word) Married

DATE OF BIRTH 10 Dec. 20, 1834
(Month) (Day) (Year)

AGE 86 yrs. 2 mos. 18 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE (City or town, State or foreign country) Indiana

PARENTS
NAME OF FATHER Elijah Wright
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Lucinda Lechford
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucinda White
(ADDRESS) Stewartville Mo

Filed April 18 1911
J. H. Arnold
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 18, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 5th, 1910, to March 24th, 1911, that I last saw her alive on March 24th, 1911, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Intra capsular fracture of hip joint
1868 (Duration) 13 yrs. 8 mos. 13 ds.
1943
Contributory Old age
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Amherlin M. D.
April 15 1911 (Address) Le Centre Dale 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 Stewartville Mo DATE OF BURIAL April 18, 1911
UNDERTAKER Geo W McNeill ADDRESS Amity 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*, *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.)



PLACE OF DEATH

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

Township _____

Registration District No. 257File No. 13909or
Village _____

Primary Registration District No. _____

Registered No. _____

or
City _____ (NO. _____)

St.: _____ Ward) _____

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

FULL NAME

Mary Jane Legardee

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH _____, 191____
(Month) (Day) (Year)AGE _____ yrs. _____ mos. _____ 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)PARENTS
NAME OF FATHER _____
BIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHER _____
BIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4-18 191____
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
_____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of Femur
By accidental Fall

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Exhaustion
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Imberlin M. D.
191____ (Address) DeKalb*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. 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

UNDERTAKER

ADDRESS

Original file, date _____, 19____

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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