

PLACE OF DEATH

County Douglas
 Township Clatsop
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

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

Registration District No. 278 File No. 13929
 Primary Registration District No. 6394 Registered No. 8

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

FULL NAME Juanita Palmer

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE married
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH June 4, 1890
 (Month) (Day) (Year)

AGE 20 yrs. 10 mos. 24 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) Farmers

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

NAME OF FATHER J. H. Hinton

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

MAIDEN NAME OF MOTHER Sara Batterson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Fisher Palmer

(ADDRESS) Cabool Mo.

Filed Apr 9 1911 U. H. Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 28, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 7, 1911, to Apr 28, 1911, that I last saw her alive on Apr 23, 1911, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
75 (Duration) 2 yrs. 2 mos. 0 ds.

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

(Signed) L. M. Edens 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?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Pine Bluffs City DATE OF BURIAL Apr 28 1911

UNDERTAKER Charles E. Schield ADDRESS Cabool

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*, *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

*Douglas
Clinton*

Township

Village

City

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

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

Registration District No.

278

File No.

Primary Registration District No.

5394

Registered No.

5

(NO.)

St.

Ward

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

FULL NAME

Juanita Palmer

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* SINGLE MARRIED WIDOWED OR DIVORCED *Married*

DATE OF BIRTH *June 4, 1890*
(Month) (Day) (Year)

AGE *20 yrs. 10 mos. 24 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) *Former*

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

PARENTS
NAME OF FATHER *L. W. Patton*
BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ohio*
MAIDEN NAME OF MOTHER *Sarah Patton*
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ohio*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Felix Palmer*
(ADDRESS) *Carroll Mo.*

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Apr 28, 1911*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *March 7, 1911*, to *Apr 28, 1911*, that I last saw her alive on *Apr 23, 1911*, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows: *Pulmonary Tuberculosis*

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

Contributory (SECONDARY) _____
(Signed) *S. M. Cline* M. D.
Apr 28, 1911 (Address) *Carroll 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 *Carroll Mo.* DATE OF BURIAL *Apr 30, 1911*

FILED *Apr 9, 1911* REGISTRAR *J. C. Schult*

Original file, date.

Apr 9, 1911

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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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.)

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