

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

PLACE OF DEATH  
County Pettis  
Township Sedalia  
or  
Village  
or  
City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 668 File No. 15286  
Primary Registration District No. 5889 Registered No. 104

FULL NAME not named

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

PERSONAL AND STATISTICAL PARTICULARS

|                                                                                                                                                                           |                               |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------|
| SEX<br><u>Female</u>                                                                                                                                                      | COLOR OR RACE<br><u>White</u> | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word) |
| DATE OF BIRTH<br><u>Jan</u> <u>26</u> , 19 <u>11</u><br>(Month) (Day) (Year)                                                                                              |                               |                                                                 |
| AGE<br><u>X</u> yrs. _____ mos. _____ ds.                                                                                                                                 |                               | IF LESS than<br>1 day, _____ hrs.<br>or _____ min.?             |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |                               |                                                                 |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Sedalia Mo.</u>                                                                                                 |                               |                                                                 |

|         |                                                                                     |
|---------|-------------------------------------------------------------------------------------|
| PARENTS | NAME OF FATHER<br><u>Unknown</u>                                                    |
|         | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>unknown</u>     |
|         | MAIDEN NAME OF MOTHER<br><u>Bulah Fay Whitman</u>                                   |
|         | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Sedalia Mo.</u> |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. F. Staats  
(ADDRESS) Sedalia Mo.

Filed April 5 1911 Sam Kelly  
Registrar  
Deputy

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Jan. 26, 1911 to \_\_\_\_\_, 1911,  
that I last saw her alive on Jan. 26, 1911,  
and that death occurred, on the date stated above, at 4:20 PM.  
The CAUSE OF DEATH\* was as follows:

Spina Bifida LP  
15413  
(Duration) \_\_\_\_\_ yrs. 7 weeks 2 ds.

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

(Signed) E. F. Staats M. D.  
April 6, 1911 (Address) 114 Madison Sedalia 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 Family Burial Ground DATE OF BURIAL March 18, 1911  
UNDERTAKER No Undertaker ADDRESS \_\_\_\_\_

# 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

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHREGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.County PolkTownship Sedalia

Village \_\_\_\_\_

City \_\_\_\_\_

Registration District No. 668Primary Registration District No. 5889File No. 15286Registered No. 104(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number)FULL NAME Unnamed

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(If write the word)DATE OF BIRTH Jan 26, 1911  
(Month) (Day) (Year)AGE 23 If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min. 7  
yrs. 2 mos. 13 ds.OCCUPATION  
(a) Trade, profession, or  
particular kind of work none(b) General nature of industry,  
business, or establishment in  
which employed (or employer)BIRTHPLACE  
(City or town,  
State or foreign country) Sedalia Mo

PARENTS

NAME OF  
FATHER Mr. J. H. StutzBIRTHPLACE  
OF FATHER  
(City or town, State or foreign country) St. Louis MoMAIDEN NAME  
OF MOTHER Emily WhitmanBIRTHPLACE  
OF MOTHER  
(City or town, State or foreign country) Sedalia Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Stutz(ADDRESS) Sedalia MoFiled April 5, 1911, Sam Kelly  
Bess Kalus REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 18, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from  
Jan 26, 1911, to Jan 26, 1911,  
that I last saw him alive on Jan 26, 1911,  
and that death occurred, on the date stated above, at prop m.The CAUSE OF DEATH\* was as follows:  
Serious Bronchitis(Duration) 2 yrs. 2 mos. 2 ds.Contributory  
(SECONDARY)(Duration) 2 yrs. 2 mos. 2 ds.(Signed) E. J. Stutz M. D.Per 6, 1911 (Address) 104 W. Main Sedalia 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

DATE OF BURIAL

UNDERTAKER

ADDRESS

Original file, date, \_\_\_\_\_, 19\_\_\_\_

All information called for must be written on this Supplementary Certificate

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

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