

PLACE OF DEATH

County Saline
 Township Cambridge
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 799 File No. 16579-2
 Primary Registration District No. 6037B Registered No. 16579-2

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

FULL NAME Marie Beebe

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Dec 1</u> , 19 <u>09</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>4</u> mos. <u>2</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>-</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>-</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Saline Co Mo</u>		
PARENTS	NAME OF FATHER <u>G. W. Beebe</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Saline Co Mo</u>
	MAIDEN NAME OF MOTHER <u>Mary Embury</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Apr. 4, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 6, 1911, to Apr. 4, 1917, that I last saw her alive on Apr. 3, 1917, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Intens. Colitis
119B 1- 1/2
(Duration) _____ yrs. _____ mos. 28 ds.

Contributory Scarlet Fever
(SECONDARY) (Duration) _____ yrs. _____ mos. 15 ds.

(Signed) C. W. Coakwell M. D.
4/11, 1917 (Address) Plater 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Proffitt
 (ADDRESS) Plater Mo

Filed Apr 5, 1917 P. A. Howard
 REGISTRAR

PLACE OF BURIAL OR REMOVAL
High Hill Cemetery
 DATE OF BURIAL
4/5, 1917
 UNDERTAKER
Sam Hill & Co
 ADDRESS
Plater 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, 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 Saline
 Township Cambridge
 or
 Village _____
 or
 City _____

REGISTRARS SHALL NOT RE-
 CEIVE 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. 799 File No. _____
 Primary Registration District No. 6037B Registered No. _____

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

FULL NAME

Marie Beeler

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED single
 DATE OF BIRTH Dec. 1 1909
 (Month) (Day) (Year)
 AGE 11 yrs. 4 mos. 3 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) _____

BIRTHPLACE (City or town, State or foreign country) Saline Co Mo.

PARENTS
 NAME OF FATHER G. W. Beeler
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Saline Co Mo.
 MAIDEN NAME OF MOTHER Joy Embrey
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Proffitt
 (ADDRESS) Slater Mo.

Filed Aug 4 1911 R. A. Jenkins REGISTRAR

REGISTRAR

Original file, date Apr 5 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 4 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 6 1911, to Apr 4 1911, that I last saw her alive on Apr 3 1911, and that death occurred, on the date stated above, at 7 P M

The CAUSE OF DEATH* was as follows:

antero - Colitis

Contributory (SECONDARY) Scarlet fever
 (Duration) ___ yrs. ___ mos. 28 ds.

(Signed) C. W. Caldwell
4-11 1911 (Address) Slater 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 High Hill Cem. DATE OF BURIAL 4-5 1911

UNDERTAKER Am. Bk. & Bldg. Co. ADDRESS Slater Mo.

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.)