

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

PLACE OF DEATH

County Carroll

Township Stokis Mound Registration District No. 139

File No. 27640

Village _____ Primary Registration District No. 5199

Registered No. 16

City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Matilda Finner

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>July 22, 1900</u> (Month) (Day) (Year)		
AGE <u>11 yrs.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Schoolgirl</u> (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 <u>Paul Finner</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Millersby Wis.</u>
	MAIDEN NAME OF MOTHER <u>Minnie Shutz</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Woburn Me.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Finner

(ADDRESS) Lina Mo.

Filed Aug 15 1911 O.R. Edmonds

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Aug 11, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 23, 1911, to Aug 11, 1911, that I last saw her alive on Aug 11, 1911, and that death occurred, on the date stated above, at 10:57 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid fever

Contributory Malaria
(Duration) _____ yrs. _____ mos. 19 ds.

(Signed) O.R. Edmonds M. D.
Aug 11, 1911 (Address) Lina 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. _____ da. In the State _____ yrs. _____ mos. _____ da.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL <u>Clona Cemetery</u>	DATE OF BURIAL <u>Aug 12, 1911</u>
UNDERTAKER <u>W.A. Foraker</u>	ADDRESS <u>Lina Mo.</u>

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 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Carroll
Township Stokes mound
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 13.9 File No. _____
Primary Registration District No. 5-199 Registered No. 16

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

FULL NAME Matilda Finn

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH July 22, 1900
(Month) (Day) (Year)

AGE 11 yrs. 19 ds.
IF LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION (a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) Carroll Co.

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

NAME OF FATHER Paul Finn

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

MAIDEN NAME OF MOTHER Minnie Shutz

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Minnie Finn

(ADDRESS) Lisa Mo

Filed Aug 15 1911 O.R. Edmonds REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 11, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 23, 1911, to Aug 11, 1911, that I last saw her alive on Aug 11, 1911, and that death occurred, on the date stated above, at 10^{52a} m.

The CAUSE OF DEATH* was as follows: Typhoid fever

(Duration) yrs. ___ mos. 19 ds.

Contributory Malaria (SECONDARY)

(Duration) yrs. ___ mos. ___ ds.

(Signed) O.R. Edmonds M. D. (Address) Lisa 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 Clona Cemetery DATE OF BURIAL Aug 12 1911

UNDERTAKER W A Foraker ADDRESS Lisa Mo

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.)

Original