

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

PLACE OF DEATH

County Clay
Township Holt
or
Village Holt
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 199 File No. 27762
Primary Registration District No. 4119 Registered No. _____

FULL NAME Rachel Horn

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 2, 1916
(Month) (Day) (Year)

DATE OF BIRTH Aug 2 1838
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1910, to Aug 2, 1916,
that I last saw her alive on Aug 2, 1916,
and that death occurred, on the date stated above, at 3:30 m.

AGE 73 yrs. 0 mos. 0 ds. IF LESS than
1 day, _____ hrs.
or _____ min.?

The CAUSE OF DEATH* was as follows
Chronic Gastritis
1170
103 (Duration) 3 yrs. _____ mos. _____ ds.

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 90

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

PARENTS
NAME OF FATHER John Funtzcker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Bettie Funtzcker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. T. Tattler M. D.
Aug 2, 1916 (Address) Holt, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marion Horn
(ADDRESS) Holt, Mo.

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 _____

Filed Aug 3, 1916 W. L. Pleaves
REGISTRAR

PLACE OF BURIAL OR REMOVAL New Hope DATE OF BURIAL Aug 3, 1916
UNDERTAKER Leonard Fry ADDRESS Holt, 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.)



County Clay Registration District No. 199 File No. _____
 Township _____ or _____ Village Holt Primary Registration District No. 4119 Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Rachel Horn (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE Married MARRIED WIDOWED OR DIVORCED (Write "Widowed")
 DATE OF BIRTH Aug. 2, 1878 (Month) (Day) (Year)
 AGE 43 yrs. 0 mos. 0 ds. IF LESS than 1 day, hrs. or mins.
 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 BIRTHPLACE (City or town, State or foreign country) Charleston, W. Va.
 NAME OF FATHER John H. Horn
 BIRTHPLACE OF FATHER (City or town, State or foreign country) W. Va.
 MAIDEN NAME OF MOTHER Peter
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) W. Va.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 2, 1911 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 1911, to Aug 2, 1911,
 that I last saw her alive on Aug 2, 1911,
 and that death occurred, on the date stated above, at 3:30 m.
 The CAUSE OF DEATH* was as follows:
Chronic Gastritis
 (Duration) 3 yrs. _____ mos. _____ ds.
 Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) H. P. Salter M. D.
7-2 1911 (Address) Holt, W. Va.
 *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 New Hope DATE OF BURIAL 8-5 1911
 UNDERTAKER Edward Fry ADDRESS Holt, W. Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Marion Horn
 (ADDRESS) Holt, W. Va.
 Filed Aug 3 X 1911 W. L. Lile REGISTRAR

Revised United States Standard Certificate of Death

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

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