

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

PLACE OF DEATH

County Greene

Township Walnut Grove

Village _____

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

Registration District No. 325

File No. 28051

Primary Registration District No. 3410

Registered No. 13

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

FULL NAME Mamie Killingsworth

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 6, 1911
(Month) (Day) (Year)

DATE OF BIRTH Sept 2, 1901
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 12, 1911, to Aug 6, 1911, that I last saw her alive on Aug 6, 1911, and that death occurred, on the date stated above, at 11³⁰ a.m.

AGE 9 yrs. 11 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work school girl
(b) General nature of industry, business, or establishment in which employed (or employer) 0*

Aortic Stenosis

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

(Duration) 4 mos. ds. Contributory Tonsillitis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Clay Killingsworth

(Signed) L. M. McClure M. D.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Greene Co Mo

Aug 7, 1911 (Address) Walnut Grove Mo

MAIDEN NAME OF MOTHER Lora Waddell

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(Informant) Geo Killingsworth

Where was disease contracted If not at place of death? _____

(ADDRESS) Phenix Mo

Former or usual residence _____

Filed Aug 7, 1911 L. M. McClure

PLACE OF BURIAL OR REMOVAL Williamson Cem DATE OF BURIAL _____ 1911

UNDERTAKER J. R. Brinn & Sons ADDRESS Walnut Grove Mo

REGISTRAR

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*, *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

County Green
 Township Walnut Grove
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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. 325 File No. _____
 Primary Registration District No. 5450 Registered No. 13

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

FULL NAME

Minnie Willingworth

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF RACE W
 SINGLE MARRIED WIDOWED OR DIVORCED
 (Write the word) S

DATE OF BIRTH 9-2-90
 (Month) (Day) (Year)

AGE 9 11 4
 yrs. mos. 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)

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

PARENTS
 NAME OF FATHER Clay Willingworth
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Greeney, Mo.
 MAIDEN NAME OF MOTHER Miss Marshall
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Greeney, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Geo. Willingworth
 (ADDRESS) Greeney, Mo.

Filed 8/7 1911 Registrar Geo. Willingworth

Original file, date _____, 19____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-6, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to 8-6, 1911, that I last saw her alive on 8-6, 1911, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:
Acute Stenosis

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

(Signed) Dr. M. C. ... M. D.
 (Address) Walnut Grove

*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 usual residence _____

PLACE OF BURIAL OR REMOVAL Walnut Grove

DATE OF BURIAL 8/7, 1911

UNDERTAKER Geo. Willingworth

ADDRESS _____

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]

28051

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