

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Waco
Township Richland
or
Village _____
or
City _____ (NO. _____)Registration District No. 918 File No. 98839
Primary Registration District No. 4342 Registered No. 3
6242 St.: _____ Ward) _____

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

FULL NAME Emma S Davidson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)DATE OF BIRTH May 25 1868
(Month) (Day) (Year)AGE 48 yrs. 2 mos. 27 ds. IF LESS than 1 day, ___ hrs. or ___ min.?OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed, (for employer) SelfBIRTHPLACE (City or town, State or foreign country) DelPARENTS NAME OF FATHER Thos. RavenscroftBIRTHPLACE OF FATHER (City or town, State or foreign country) OhioMAIDEN NAME OF MOTHER Anna G. HonlaoreBIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Susie W. Cornac(ADDRESS) Lacroisse, Wis.Filed 8/22 1911 J. P. Fustie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 21, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug 20, 1911, to Aug 21, 1911, that I last saw her alive on Aug 21 8 P.M., 1911, and that death occurred, on the date stated above, at 11 P.M. The CAUSE OF DEATH* was as follows:Respiratory Circumstances
Uterine appendicitis
(Duration) 2 yrs. 6 mos. - ds.Contributory Respiratory - Circumstances
(SECONDARY) (Duration) 7 yrs. 6 mos. - ds.(Signed) J. P. Fustie M. D.
(Address) Lacroisse, Wis.

*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 _____ 1911UNDERTAKER Gooding & Blum ADDRESS Lacrosse, Wis.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.)

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.

Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX.....

COLOR OR RACE.....

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*write the word*)

DATE OF BIRTH.....

(Month).....(Day).....(Year)

AGE.....

IF LESS than
1 day,.....hrs
or.....min.?

OCCUPATION.....

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE.....

(City or town, State or foreign country)

NAME OF FATHER.....

BIRTHPLACE OF FATHER.....

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER.....

BIRTHPLACE OF MOTHER.....

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed

191.....

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month).....(Day).....191.....(Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....(Duration).....yrs.....mos.....ds.

Contributory

(SECONDARY)

(Signed).....(Duration).....yrs.....mos.....ds.

....., 191.....(Address).....M. D.

* 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. 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

County Macon
Township Richland
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 918 File No. _____
Primary Registration District No. 6242 Registered No. 3

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

FULL NAME Emma S. Davidson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (*If write the word*) married
DATE OF BIRTH May 25, 1863
(Month) (Day) (Year)
AGE 48 yrs. 2 mos. 27 ds. if LESS than 1 day, ___ hrs. or ___ min.

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

BIRTHPLACE (City or town, State or foreign country) Ill.

PARENTS NAME OF FATHER Thos. Ravenscraft BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Anna G. Honlacre BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Susie McCormac
(ADDRESS) Lacrosse, Mo.

Filed Aug 22, 1911 J.P. Foster REGISTRAR

Original file, date 8/22, 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 21, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Aug. 20, 1911, to Aug. 21, 1911, that I last saw her alive on Aug 21 8 P. M., 1911, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma uterine appendage
(Duration) 2 yrs. 6 mos. ___ ds.

Contributory Recurrent carcinoma (SECONDARY) (Duration) ___ yrs. 6 mos. ___ ds.

(Signed) J.P. Foster M. D. Aug 22, 1911 (Address) Lacrosse, 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? _____
Ferner or usual residence _____

PLACE OF BURIAL OR REMOVAL Harrods Ill. DATE OF BURIAL Aug 24, 1911

UNDERTAKER Godddig & Christie ADDRESS La Plata, 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]]

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.)

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