

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

PLACE OF DEATH

County Pettis

Township _____

or

Village _____

or

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

Registration District No. 668

File No. 29098

Primary Registration District No. 3032

Registered No. 208

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

FULL NAME Mary Lee

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) unknown

DATE OF DEATH Aug 10th, 1911
(Month) (Day) (Year)

DATE OF BIRTH about 1859
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 11th, 1911, to Aug 10th, 1911, that I last saw her alive on Aug 10th, 1911,

AGE About 52 yrs. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 9:30 p.m.

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) not given

The CAUSE OF DEATH* was as follows:

Malarial fever
Malaria
38

BIRTHPLACE (City or town, State or foreign country) Keokuk

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

NAME OF FATHER Unknown

Contributory nothing
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) A. S. Walden M. D.
Aug 12, 1911 (Address) 117 East Main

MAIDEN NAME OF MOTHER Unknown

*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) Unknown

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) Martha Crawford
(ADDRESS) Sedalia Mo.

Former or usual residence _____

Filed Aug 17, 1911 Sam Kelly REGISTRAR
Beas Katers Deputy

PLACE OF BURIAL OR REMOVAL Atchinsons Hou. DATE OF BURIAL Aug-17, 1911

UNDERTAKER Sedalia Undertaking and Carpet Co. ADDRESS Sedalia 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*, *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.)



County Pettis
Township _____
or
Village _____
or
City Sedalia (NO. _____ St.: _____ Ward _____)

Registration District No. 668 File No. _____
Primary Registration District No. 3032 Registered No. 208

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

FULL NAME

Mary Lee

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Color SINGLE MARRIED WIDOWED OR DIVORCED Unknown
(If file the word)
DATE OF BIRTH About 1859
(Month) (Day) (Year)
AGE About 52 yrs. mos. ds. IF LESS than 1 day, hrs. or min. 2
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) Ken. Unknown
PARENTS
NAME OF FATHER Unknown
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) Martha Crawford
(ADDRESS) Sedalia Mo

Filed Aug 12 1911 Sam Kelly REGISTRAR
Bees Kabas Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 10 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Aug 11 1911, to Aug 10 1911,
that I last saw her alive on Aug 10 1911,
and that death occurred, on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:

Malaria fever

(Duration) yrs. 1 mos. 1 ds.
Contributory (SECONDARY) Nothing
(Duration) yrs. mos. ds.
(Signed) C. S. Walden M. D.
Aug 12 1911 (Address) 117 East Morgan Sedalia 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 Chickson Kay DATE OF BURIAL Aug 12 1911

UNDERTAKER Sedalia Und. Co ADDRESS Sedalia Mo

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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