

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Scott
Township Riley
or
Village
or ~~Forrest Mo~~
City Forrest Mo (NO. _____) St.: _____ Ward _____

Registration District No. 816 File No. 30349

Primary Registration District No. 6065 Registered No. 74

FULL NAME William James Cooper

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 WIDOWED OR DIVORCED (If write the word) Married
DATE OF BIRTH Nov 29 1848
(Month) (Day) (Year)
AGE 62 yrs. 8 mos. 21 ds. If LESS than 1 day _____ hrs. or _____ min.?

DATE OF DEATH Aug 30 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 10, 1911, to Aug 20, 1911, that I last saw her alive on Aug 20, 1911, and that death occurred, on the date stated above, at 10 1/2 1/2

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

The CAUSE OF DEATH* was as follows:
Chronic Gastritis

BIRTHPLACE Bellaire, Ky.
(City or town, State or foreign country)

(Duration) _____ yrs. _____ mos. 10 ds.

PARENTS
NAME OF FATHER John Adams
BIRTHPLACE OF FATHER Not known
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Blackburn
BIRTHPLACE OF MOTHER Not known
(City or town, State or foreign country)

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. J. Mayfield M. D.
Aug 20 1911 (Address) Forrest Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Cooper
(ADDRESS) Marissa Ill

*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 ✓

FILE Aug 22 1911 W. Sample REGISTRAR

PLACE OF BURIAL OR REMOVAL Marissa Ill SITE OF BURIAL Sp 22/11 1911
UNDERTAKER R. F. Funder ADDRESS Forrest Mo

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

Scott

Township

Kelso

or

Village

or

City

Registration District No.

816

File No.

Primary Registration District No.

6065

Registered No.

74

(NO.

St.

Ward

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

FULL NAME

Annice Jane Cooper

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

Nov 29, 1848
(Month) (Day) (Year)

AGE

62 yrs. 8 mos. 21 ds.
If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

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

Dressmaker

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

BIRTHPLACE

(City or town, State or foreign country)

Colo Mines
"EMILE"

NAME OF FATHER

John Anderson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Port Iron

MAIDEN NAME OF MOTHER

Mary Blackburn

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Port Iron

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Cooper
Marion Ill.
(ADDRESS)

FILE

1911

Aug 22 X Ed Sample X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

8-20, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from

8-10, 1911, to 8-20, 1911

that I last saw her alive on 8-20, 1911

and that death occurred, on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

Senility

(Duration) ___ yrs. ___ mos. 26 ds.

Contributory

Heart Enlargement

(SECONDARY)

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

(Signed)

L. S. Mayfield M. D.
8-20, 1911 (Address) Illinois, Ill.

*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

Marion Ill. 8-22, 1911

UNDERTAKER

ADDRESS

A. W. Wenden Marion Ill.

Original file, date

Aug 22, 1911

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]

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