

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 Pauldolph
Township _____
or
Village _____
or
City Moberly (NO. 506 Union St. St. 1st Ward)

Registration District No. 735 File No. 32392
Primary Registration District No. 3034 Registered No. 137

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

FULL NAME Mrs. Jane Aiken

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Widow
(If wife the word)

DATE OF BIRTH June 16, 1837
(Month) (Day) (Year)

AGE 74 yrs. 3 mos. 10 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER John Reed
BIRTHPLACE OF FATHER (City or town, State or foreign country) Scotland
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Aiken
(ADDRESS) Moberly Mo

Filed 9/28/1911 REGISTRAR W. C. Means

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 26, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from September 8, 1911, to Sept 25, 1911, that I last saw her alive on Sept 25, 1911, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
11913
1180 (Duration) 10 yrs. 23 mos. 5 ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) W. C. Means M. D. Sept 28, 1911 (Address) Moberly 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 ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Darland Cemetery DATE OF BURIAL Sept 28, 1911
UNDERTAKER Martin & Mahan ADDRESS Moberly 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 show (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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County

Randolph

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Township

Registration District No.

735

File No.

or Village

Primary Registration District No.

3034

Registered No.

137

City

Moberly

(NO. 506 Vine St. St. Ward)

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

FULL NAME

Jane Aiken (Aiken)

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

W

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

widow

DATE OF BIRTH

6-16-1837
(Month) (Day) (Year)

AGE

74 yrs. 3 mos. 10 ds.

IF LESS than
1 day, hrs.
or min.

OCCUPATION

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

Housekeeper

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

BIRTHPLACE

(City or town, State or foreign country)

Scotland

NAME OF FATHER

John Aiken

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Scotland

MAIDEN NAME OF MOTHER

Sandra Aiken

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

" "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Aiken
Moberly Mo.

(ADDRESS)

Filed

9/28/1911 X B. C. Bell
REGISTRAR

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

9-26

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

9/18, 1911, to 9/25, 1911,

that I last saw him alive on 9/25, 1911,

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

The CAUSE OF DEATH* was as follows:

Dysentery & Enteritis

Contributory

(SECONDARY)

Dysentery & Enteritis

(Signed)

9/28, 1911 (Address) Moberly

*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

Oakland Cemetery

DATE OF BURIAL

9-28, 1911

UNDERTAKER

Martin & Arthur Moberly

ADDRESS

Moberly

Original file, date

9-28

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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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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