

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 Baldwell
 Township V
 or Village V
 or City Hamilton (NO. _____) St. 2nd Ward

Registration District No. 96 File No. 33858
 Primary Registration District No. 4058 Registered No. 31

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

FULL NAME Katherine Leeper

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April 2, 1990
(Month) (Day) (Year)

AGE 21 yrs. 6 mos. 21 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Brazzelle Caldwell, Mo

PARENTS
 NAME OF FATHER Calvin Carroll Leeper
 BIRTHPLACE OF FATHER Yonkers Ill
 MAIDEN NAME OF MOTHER Bertha Wallace
 BIRTHPLACE OF MOTHER Nebraska City Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) C. P. Leeper

(ADDRESS) Excelsior Springs Mo

Filed Oct 23 1911 Timley Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 23rd, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 21, 1911, to Oct 23, 1911, that I last saw her alive on Oct 23, 1911, and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH* was as follows:
Diabetes mellitus
59 50

(Duration) 1 yrs. 6 mos. 1 ds.

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

(Signed) _____ M. D.
 _____ 1911 (Address)

*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 Excelsior Springs Mo

PLACE OF FUNERAL OR CREMATION Hamilton Mo DATE OF BURIAL Oct 24, 1911

UNDERTAKER Joseph Houghton ADDRESS Hamilton 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.)



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

PLACE OF DEATH
 County Caldwell
 Township _____
 or
 Village Hamilton
 or
 City _____ (NO. _____)

Registration District No. 96 File No. _____
 Primary Registration District No. 4058 Registered No. 31
 St. 2 Ward _____

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

FULL NAME Katherine Leeper

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
 (Write the word)
 DATE OF BIRTH April 2, 1890
 (Month) (Day) (Year)
 AGE 21 yrs. 6 mos. 21 ds.
 If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
 NAME OF FATHER Calven C. Leeper
 BIRTHPLACE OF FATHER Monmouth Ill.
 MAIDEN NAME OF MOTHER Mary Herbert Wallace
 BIRTHPLACE OF MOTHER Nebraska City Neb.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) C. C. Leeper

(ADDRESS) Excelsior Springs
 Filed Oct 23 1911 Finley Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 23, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Oct 21, 1911, to Oct 23, 1911,
 that I last saw her alive on Oct 23, 1911,
 and that death occurred, on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
 (Duration) 1 yrs. 6 mos. ds.

Contributory _____
 (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. ds.
 (Signed) Finley Brown M.D.
Oct 23, 1911 (Address) Hamilton 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 Excelsior Springs

PLACE OF BURIAL OR REMOVAL Hamilton Mo DATE OF BURIAL Oct 24, 1911
 UNDERTAKER Geo Haughton ADDRESS Hamilton Mo

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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