

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

34142

PLACE OF DEATH

County Dallas
Township Grant
or
Village _____
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 24 File No. _____
Primary Registration District No. D335 Registered No. _____

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

FULL NAME

Sarah Elizabeth Marsh

PERSONAL AND STATISTICAL PARTICULARS

5 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH Aug 21, 1847
(Month) (Day) (Year)
AGE 64 yrs. 16 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Sept 7, 1911
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased, from Sept 1, 1911, to Sept 6, 1911, that I last saw her alive on Sept 6, 1911, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:
Dropsy, nephritis, heart disease & liver dis
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BIRTHPLACE (City or town, State or foreign country) Iowa

95B (Duration) ___ yrs. ___ mos. ___ ds.
125B Contributory dis located shoulder
(SECONDARY) (Duration) ___ yrs. ___ mos. 7 ds.

PARENTS
NAME OF FATHER Wm Arnold
BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa
MAIDEN NAME OF MOTHER Nancy E Gallohan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

(Signed) W E Gannon M. D.
Sept 8, 1911 (Address) Lombsburg mo
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sol Marsh
(ADDRESS) Lombsburg mo

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 _____

Filed Oct 13, 1911 W E Gannon
REGISTRAR

PLACE OF BURIAL OR REMOVAL Lombsburg mo DATE OF BURIAL Sept 8, 1911
UNDERTAKER Leighton Rice ADDRESS Lombsburg mo

This document may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

(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 (<i>Specify the word</i>)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____ 191_____

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:

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) _____

Contributory
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____, 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. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

Filed _____, 191____, REGISTRAR _____

This statement of OCCUPATION is very important.

PLACE OF BIRTH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Dallas Registration District No. 242 File No. _____
 Township Grant or Village _____ Primary Registration District No. 1380 Registered No. 9
 City _____ (NO. _____ St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Elizabeth Marsh

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
 DATE OF BIRTH Aug 21 1847 (Month) (Day) (Year)
 AGE 64 yrs. 16 mos. 16 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 (or employer) General

DATE OF DEATH Sept 7 1911 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Sept 1 1911, to Sept 4 1911, that I last saw her alive on Sept 4 1911, and that death occurred, on the date stated above, at 12 in the _____
 The CAUSE OF DEATH* was as follows:
Chronic Nephritis

BIRTHPLACE (City or town, State or foreign country) Tenn
 NAME OF FATHER Wm. North
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
 MAIDEN NAME OF MOTHER Elizabeth Callahan
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. 7 ds.
 (Signed) W. C. Sammons M. D. Sept 8 1911 (Address) Cornsburg, Mo.
 *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Sol Marsh
 (ADDRESS) Cornsburg, Mo.
 Filed Oct 24 1911 REGISTRAR Teyton Rich

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 Cornsburg, Mo. DATE OF BURIAL Sept 8 1911
 UNDERTAKER Teyton Rich ADDRESS Adv. C. Cornsburg, Mo.

Original file, date OCT 19____ 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*, *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*, *peritonaeum*, etc., *Carcinoma*, *Ser-*

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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