

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

PLACE OF DEATH

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

Registration District No. 576 File No. 35297
Primary Registration District No. 5774 Registered No. 12

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

FULL NAME Dorah McMillon

PERSONAL AND STATISTICAL PARTICULARS

7 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____ 9 _____ 21, 1911
(Month) (Day) (Year)

DATE OF BIRTH _____ Nov. _____ 28, 1874
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 9-20, 1911, to 9-21, 1911, that I last saw her alive on 9-20, 1911, and that death occurred, on the date stated above, at 3 P. m.

AGE _____ 36 yrs. 9 mos. 23 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping

Branchitis
1012 D
167
(Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory Senility
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

PARENTS NAME OF FATHER Dont Know BIRTHPLACE OF FATHER (City or town, State or foreign country) Shos McMillin Dont Know MAIDEN NAME OF MOTHER Dont Know BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

(Signed) J. L. Gillsland M. D. 9-22, 1911 (Address) Olean 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) Will Roark (ADDRESS) Enon, 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 _____

Filled Oct 26, 1911 W. J. Finke REGISTRAR

PLACE OF BURIAL OR REMOVAL High Point, Mo. DATE OF BURIAL 9/22, 1911 UNDERTAKER J. A. Robertson ADDRESS Olean, 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.)



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.

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PLACE OF DEATH
County Monteau
Township Oversink Fork
or
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or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 576 File No. 95997
Primary Registration District No. 5774 Registered No. _____

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

FULL NAME Sarah Mc Millon

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Nov. 28, 1824</u> (Month) (Day) (Year)		
AGE <u>86</u> yrs. <u>9</u> mos. <u>23</u> ds. If LESS than 1 day, ____ hrs. or ____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeping</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Tennessee</u>		
PARENTS	NAME OF FATHER <u>Dout. I know</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Thos. McMillon, Dout. I know</u>	
	MAIDEN NAME OF MOTHER <u>Dout. I know</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dout. I know</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>9 21, 1911</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>9-20</u> , 1911, to <u>9-21</u> , 1911, that I last saw h. <u>EX</u> alive on <u>9-20</u> , 1911, and that death occurred, on the date stated above, at <u>8 P.</u> m.
The CAUSE OF DEATH* was as follows: <u>Bronchitis</u>
Contributory (SECONDARY) <u>Senility</u> (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) <u>J. A. Gilleland</u> M. D. <u>9-22, 1911</u> (Address) <u>Olean, Mo.</u>
*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) Will Rook
(ADDRESS) Enon Mo.
Filed 9/22, 1911. W. S. Allen
REGISTRAR

PLACE OF BURIAL OR REMOVAL High Point Mo DATE OF BURIAL 9/22, 1911
UNDERTAKER J. A. Robertson ADDRESS Olean Mo

Revised United States Standard Certificate of Death

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

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