

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 Oregon  
Township \_\_\_\_\_  
or  
Village Thayer  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 632 File No. 35405  
Primary Registration District No. 4382 Registered No. 14  
St.: \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Jessie R. Pierce

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED widow WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH X Do not know 1826 (Month) (Day) (Year)  
AGE 85 yrs. Do not know If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work X 0-2  
(b) General nature of industry, business, or establishment in which employed (or employer) X

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1 Sept 23, 1911 (Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from Sept 23<sup>rd</sup>, 1911, to Sept 23<sup>rd</sup>, 1911, that I last saw her alive on Sept 23<sup>rd</sup>, 1911, and that death occurred, on the date stated above, at 11 1/2 m.  
The CAUSE OF DEATH\* was as follows:  
Heart Disease  
9 1/2 (Duration) yrs. mos. ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.  
(Signed) St. C. Cantrell M. D. Sept 30, 1911 (Address) Thayer 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 \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) X Jessie  
NAME OF FATHER X Horrest  
BIRTHPLACE OF FATHER (City or town, State or foreign country) X Do not know  
MAIDEN NAME OF MOTHER X Cantrell  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) X Do not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. A. Pitchford  
(ADDRESS) Thayer Mo.

Filed Oct 2 1911 C. C. Culp REGISTRAR  
Deputy Health Commissioner

PLACE OF BURIAL OR REMOVAL Baker Cemetery DATE OF BURIAL Sept 24, 1911  
UNDERTAKER Had none. ADDRESS \_\_\_\_\_

# 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*, *Composer*, *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," "Hæmorrhage," "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.)



County Wayne Registration District No. 682 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ Primary Registration District No. 4382 Registered No. 14  
 City Wayne (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lucie R. Prince

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) \_\_\_\_\_  
 DATE OF BIRTH Don't know 826  
 (Month) (Day) (Year)  
 AGE 85 Don't know IF LESS than 1 day, hrs. or min. \_\_\_\_\_  
 yr. mos. ds. or min. \_\_\_\_\_  
 OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

PARENTS  
 NAME OF FATHER Frank M. Prince  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know  
 MAIDEN NAME OF MOTHER Antell  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Lucie R. Prince  
 (ADDRESS) Wayne Mo.

Filed Dec 11 1914 R. C. Carl  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 22, 1914  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1914, to 9-23, 1914,  
 that I last saw her alive on 9-22, 1914,  
 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:  
Progressive Hypertrophy of Old Heart  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) W. C. Carl M. D.  
9-26, 1914 (Address) Wayne 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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Wayne Mo. DATE OF BURIAL 9-27 1914  
 UNDERTAKER Had none ADDRESS \_\_\_\_\_

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