

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 Pike
Township Pine
or
Village
or
City Frankford (NO. _____ St. _____ Ward _____)

Registration District No. 688 File No. 35558
Primary Registration District No. 5916 Registered No. 20

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

FULL NAME Mary Ann Peoples

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Black SINGLE MARRIED Married
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Sept 27th, 1886
(Month) (Day) (Year)

AGE 75 yrs. 5 mos. 26 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)

BIRTHPLACE (City or town, State or foreign country) Frankford mo

NAME OF FATHER Blair

BIRTHPLACE OF FATHER (City or town, State or foreign country) UNKNOWN

MAIDEN NAME OF MOTHER Martha Ann Blair

BIRTHPLACE OF MOTHER (City or town, State or foreign country) UNKNOWN

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) G. G. Peoples

(ADDRESS) Frankford Mo

J. J. Fenwick REGISTRAR
Filed OCT - 4 1911 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 27th, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 27th, 1911 and that death occurred, on the date stated above, at Frankford, Mo. and that I last saw deceased alive on Sept 28th, 1911

The CAUSE OF DEATH* was as follows:
Heart trouble & Kidney trouble
95 F
133 C (Duration) 3 yrs. 9 mos. 9 ds.

Contributory (SECONDARY) None (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. W. Ayres M.D.
Oct 2nd, 1911 (Address) Frankford

*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 Frankford mo DATE OF BURIAL Oct 2nd, 1911

UNDERTAKER L. W. Huskey ADDRESS Frankford 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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

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

Registration District No. 688
Primary Registration District No. 5916

File No. _____
Registered No. 20

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

FULL NAME Mary Ann Peoples

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)
DATE OF BIRTH Sept 1 1896
(Month) (Day) (Year)
AGE 35-5-26
yrs. mos. ds. if LESS than 1 day, hrs. or min.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9-29, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911,
that I last saw h_____ alive on Sept 28, 1911,
and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:

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

UNKNOWN
UNKNOWN

BIRTHPLACE (City or town, State or foreign country) Frankford, Mo.

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER Mrs. Ann Clark
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

Contributory (SECONDARY) _____
(Duration) yrs. mos. ds.
(Signed) W. J. Peoples M. D.
1911 (Address) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Peoples
(ADDRESS) Frankford, Mo.
Filed 10/4 1911 W. J. Kennedy REGISTRAR

*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 usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
ADDRESS _____
ADDRESS _____

Original file, date OCT, 1911

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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