

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

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

PLACE OF DEATH _____
 County Sullivan
 Township or Village Greenbush
 City _____ (NO. _____ St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
 Registration District No. 848 File No. 36732
 Primary Registration District No. 4514 Registered No. 14
 FULL NAME Jane Lawrence

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH Aug 29 1830
 (Month) (Day) (Year)
 AGE 81 yrs. 2 mos. 7 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) Scotland
 PARENTS:
 NAME OF FATHER Alexander White
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Scotland
 MAIDEN NAME OF MOTHER Elizabeth Douglas
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Scotland

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 29 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Oct 28, 1911, to Oct 28, 1911, that I last saw her alive on Oct 28, 1911, and that death occurred, on the date stated above, at 120 a.m.
 The CAUSE OF DEATH* was as follows:
Senile debility 154
162
fewer ounces 2 hours
pre-death (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W L Taylor M. D. (Address) Greenbush 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 _____ DATE OF BURIAL _____ 191_____
 UNDERTAKER W H Crump ADDRESS Greenbush Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Lawrence
 (ADDRESS) Greenbush Mo
 Filed Oct 30 1911 Aldo E Bailey REGISTRAR
Rep.

PLACE OF DEATH

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____ St.; _____ Ward)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____, 19____	(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) _____

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 19____

REGISTRAR

Revised United States Standard Certificate of Death

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless im-

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceas

_____ , 19____, to _____
 that I last saw h_____ alive on _____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Duration) _____ yrs. _____ mos.

(Signed)

(Address)

19____

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRAINING RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

PLACE OF DEATH
County Sullivan
Township _____
or
Village Green Castle
or
City _____ (NO. _____) St. _____ Ward _____

Registration District No. 848 File No. 6
Primary Registration District No. 451K Registered No. 14

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

FULL NAME Jane Lawrence

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Aug 29, 1830
(Month) (Day) (Year)

AGE 51 yrs. 2 mos. 7 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) Scotland

NAME OF FATHER Alexander White

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

MAIDEN NAME OF MOTHER Elizabeth Douglas

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Lawrence
(ADDRESS) Green Castle

Filed Oct 30 1911 Aldo E. Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 29, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 28, 1911, to Oct 28, 1911, that I last saw her alive on Oct 28, 1911, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Senile Debility
Saw her only once
2 hours before
death
(Duration) yrs. mos. ds.

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

(Signed) W. L. Taylor M. D.
Oct 29, 1911 (Address) Greencastle

*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 Greencastle Cemetery DATE OF BURIAL Oct 30, 1911

UNDERTAKER W. H. Crump ADDRESS Greencastle

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," "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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