

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

PLACE OF DEATH

County Adair

Township _____

Registration District No. V 4

File No. 36865

Village _____

Primary Registration District No. 3001

Registered No. 140

City Kirkville

(NO. 576 W Jeff)

St. 3 Ward)

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

FULL NAME Ida May Link

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov 26, 1911
(Month) (Day) (Year)

DATE OF BIRTH Mar 13, 1862
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 28, 1911, to Nov 26, 1911, that I last saw her alive on Nov 26, 1911, and that death occurred, on the date stated above, at 2:30 pm.

AGE 49 yrs. 8 mos. 13 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 House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer) gob

Cancer of uterus
Exhaustion
4 1/2 (Duration) 12 yrs. 12 mos. 12 ds.

BIRTHPLACE (City or town, State or foreign country) n. j.

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

NAME OF FATHER Greendike

(Signed) [Signature] M. D. _____ (Address) Kirkville

BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know

MAIDEN NAME OF MOTHER Jane

BIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

*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) May A Link

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. 1 mos. 1 ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Kirkville DATE OF BURIAL Nov 27, 1911

Filed 11-26, 1911 [Signature] REGISTRAR

UNDERTAKER H. C. Wilson ADDRESS [Address]

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.)



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

PLACE OF DEATH
County Adair
Township _____
or
Village _____
or
City Kirksville (NO. 576 W. Jeff)Registration District No. 4

File No. _____

Primary Registration District No. 3001Registered No. 140St. 3 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]FULL NAME Ida May Link

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)DATE OF BIRTH Mar 13, 1862
(Month) (Day) (Year)AGE 49 yrs. 8 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.OCCUPATION (a) Trade, profession, or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) W. J.PARENTS NAME OF FATHER GreenlakeBIRTHPLACE OF FATHER (City or town, State or foreign country) Don't knowMAIDEN NAME OF MOTHER LawreBIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary A. Link(ADDRESS) KirksvilleFiled 11-26 1914 E. C. Allison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 26, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Oct 28, 1914, to Nov 26, 1914, that I last saw her alive on Nov 26, 1914, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus
exhaustion
about
(Duration) yrs. 10 mos. ___ ds.Contributory (SECONDARY) _____
(Duration) yrs. ___ mos. ___ ds.(Signed) Geo. A. Still M. D.
11-26 1914 (Address) Kirksville

*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 Lewellyn Cem. DATE OF BURIAL Nov 27 1914UNDERTAKER H. C. Wilson ADDRESS Kirksville

Revised United States Standard Certificate of Death

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

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