

PLACE OF DEATH

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

County Osceola

Township _____

Registration District No. 213

File No. 27276

Village _____

Primary Registration District No. 3914

Registered No. 159

City Jefferson

(No. 1241 Cashley St.; 5 Ward)

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

FULL NAME Mrs Lee Crayen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED Married ~~UNMARRIED~~ ~~OR DIVORCED~~ (Insert the word)

DATE OF DEATH 11-20-1911
(Month) (Day) (Year)

DATE OF BIRTH July 18 1854
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11-16, 1911, to 11-20, 1911, that I last saw her alive on 11-20, 1911, and that death occurred, on the date stated above, at 9:30 p.m. The CAUSE OF DEATH* was as follows:

AGE 57 yrs. 4 mos. 4 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

Pneumonia
108 (Duration) yrs. ___ mos. 5 ds.

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

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

BIRTHPLACE (City or town, State or foreign country) Louisville Ky

(Signed) H. A. McDonald M. D. 11-21-1911 (Address) Jefferson City Mo

NAME OF FATHER George Crayen

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

MAIDEN NAME OF MOTHER Lee Keel

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

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Gertrude Delaplaine

Where was disease contracted if not at place of death? _____ Former or usual residence _____

(ADDRESS) Jeff City Mo

PLACE OF BURIAL OR REMOVAL For meubury. Mo DATE OF BURIAL NOV 21 1911

File NOV 21 1911 Misses [unclear] REGISTRAR

UNDERTAKER [unclear] ADDRESS Jeff City 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

4 [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, peritonaeum*, 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 Cole

Township _____

or Village _____

or City J.P.

Registration District No. 713

File No. _____

Primary Registration District No. 3014

Registered No. 159

(NO. _____ St. _____ Ward _____)

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

FULL NAME Lawrey

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED W WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH 7-1-85 (Month) (Day) (Year)

AGE 37 yrs. mos. 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) Ky.

PARENTS NAME OF FATHER Geo. C. Croyen BIRTHPLACE OF FATHER Ky. MAIDEN NAME OF MOTHER Louella BIRTHPLACE OF MOTHER Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Geo. Delaplant (ADDRESS) J.P.

Filed Nov. 21, 1911 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-21, 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11-25, 1911, to 11-21, 1911, that I last saw W alive on 11-21, 1911, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows: Pneumonia Pneumonia (Lobar) (Duration) _____ yrs. _____ mos. 3 ds.

Contributory none (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J.A. McDonald M.D. 11-25, 1911 (Address) J.C. W.

*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 Warrensburg DATE OF BURIAL 11-21, 1911

UNDERTAKER Deurich's Son ADDRESS J.P.

Revised United States Standard Certificate of Death

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

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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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