

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

PLACE OF DEATH

County Saline

Township _____

or Village Arrow Rock

or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 792

File No. 40059

Primary Registration District No. 4473

Registered No. 23

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

FULL NAME Sallie Huston

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov 19, 1911
(Month) (Day) (Year)

DATE OF BIRTH November 11, 1834
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 4, 1911, to Nov 19, 1911, that I last saw her alive on Nov 18, 1911, and that death occurred, on the date stated above, at 9:30 A. m.

AGE 77 yrs. 8 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
cardiac dropsy

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) Saline Co. Mo.

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

NAME OF FATHER Milton Wood

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

MAIDEN NAME OF MOTHER Jennette Fields

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

(Signed) _____ M. D. Nov 20, 1911 (Address) B. L. Bradshaw

*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) A. B. Morris
(ADDRESS) Arrow Rock Mo

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 _____

Filed Nov 20, 1911. M. S. McGuire
REGISTRAR

PLACE OF BURIAL OR REMOVAL Arrow Rock Cemetery DATE OF BURIAL Nov 20, 1911
UNDERTAKER _____ ADDRESS _____

CAUSE OF DEATH to be 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*, *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*, *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.)



PLACE OF DEATH

County Saline

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHTownship _____
or Arrow Rock
Village _____
or _____
City _____ (NO. _____ St. _____ Ward)Registration District No. 792
Primary Registration District No. 4473File No. 40059
Registered No. 23

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

FULL NAME

Sallie Huston

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>Nov-11</u> , 18 <u>34</u> (Month) (Day) (Year)		
AGE <u>77</u> yrs. <u>8</u> mos. <u>8</u> 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) Domestic

BIRTHPLACE
(City or town, State or foreign country) Saline Co. Mo.NAME OF FATHER Milton WoodBIRTHPLACE OF FATHER (City or town, State or foreign country) State of VirginiaMAIDEN NAME OF MOTHER Jessette FieldsBIRTHPLACE OF MOTHER (City or town, State or foreign country) State of Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Morris
(ADDRESS) Arrow Rock Mo.

Filed Nov. 20 1911 M. S. McGuire X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov-19, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov-4, 1911, to Nov-19, 1911, that I last saw h. in alive on Nov-18, 1911, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

cardiac dropsy(Duration) ___ yrs. 2 mos. ___ ds.

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

(Signed) Nov. 20 1911 (Address) B. L. Bradshaw M. D.

*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 Arrow Rock Cem DATE OF BURIAL Nov. 20 1911UNDERTAKER Spence & Diggs ADDRESS Arrow Rock Mo.

Original file, date _____, 19 _____

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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