

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty WayneTownship WilliamsRegistration District No. 892File No. 40306

Village \_\_\_\_\_

Primary Registration District No. 6193Registered No. 2

City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

FULL NAME Lou. R. Sutton

## 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>May</u> <u>26</u> , 18 <u>87</u> (Month) (Day) (Year)		
AGE <u>25</u> yrs. <u>5</u> mos. <u>5</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		

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

BIRTHPLACE  
(City or town, State or foreign country) Butter Co. Ky

PARENTS

NAME OF FATHER <u>G. B. Johnson</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Butter Co Ky</u>
MAIDEN NAME OF MOTHER <u>Rebecca Johnson</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Butter Co Ky</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) George Johnson  
(ADDRESS) Williamsville Mo  
Filed Nov. 3 1911 J. L. McGhee  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 1, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1911, to Nov 1st, 1911, that I last saw her alive on Oct 10th, 1911, and that death occurred, on the date stated above, at 4 a. m. The CAUSE OF DEATH\* was as follows:

Catarrh of throat & Lungs  
1088  
105890 (Duration) yrs. 8 mos. ds.

Contributory (Secondary) \_\_\_\_\_ (Duration) yrs. mos. ds.

(Signed) J. J. Horn M.D. M. D.  
Williamsville Mo (Address)

\*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 <u>Chapel Hill</u>	DATE OF BURIAL <u>Nov 2</u> , 191 <u>1</u>
UNDERTAKER <u>None</u>	ADDRESS

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

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_, St. \_\_\_\_\_, Ward \_\_\_\_\_)  
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH	(Month) _____, 1 _____ (Day) _____, 1 _____ (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 \_\_\_\_\_, 191\_\_\_\_, REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH**

\_\_\_\_\_, 191\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

\_\_\_\_\_, (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**Contributory**

(SECONDARY) \_\_\_\_\_, (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

191\_\_\_\_ (Address)

\*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. 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

UNDERTAKER

ADDRESS

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 Wayne  
Township Williams  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

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

Registration District No. 892 File No. 40306  
Primary Registration District No. 6193 Registered No. 2  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Low. B. Sutton

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 26, 1887  
(Month) (Day) (Year)

AGE 25 yrs. 5 mos. 5 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) Butler Co. Ky.

PARENTS  
NAME OF FATHER G. B. Johnson  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Butler Co. Ky.  
MAIDEN NAME OF MOTHER Rebecca X - X  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Butler Co. Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Johnson

(ADDRESS) Williamsville Mo.

Filed Nov. 3 1911 J. L. McGhee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov-1, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 7, 1911, to Nov-1st, 1911, that I last saw her alive on Oct. 10<sup>th</sup>, 1911, and that death occurred, on the date stated above, at 4h. am.

The CAUSE OF DEATH\* was as follows:  
Catarah of throat + lungs  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. L. Moore, M.D. M. D.  
Oct 10, 1911 (Address) Williamsville 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 Chapel Hill DATE OF BURIAL Nov. 2, 1911  
UNDERTAKER none ADDRESS \_\_\_\_\_

Original file, date Nov. 3, 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]

**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.)