

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

PLACE OF DEATH

County Marion

Township _____

Registration District No. 547

File No. 42031

or Village _____

Primary Registration District No. 3079

Registered No. 328

or City Hannibal

(NO. 217 Gorden)

St. 4 Ward _____

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

FULL NAME Rachel M. Maloy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH Dec 20, 1911
(Month) (Day) (Year)

DATE OF BIRTH Mar 10, 1856
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 13, 1911, to Dec 20, 1911, that I last saw her alive on Dec 20, 1911, and that death occurred, on the date stated above, at 12²⁵ p.m.

AGE 56 yrs. 9 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH was as follows:
Paralysis
81A
63
(Duration) 6 mos. 7 ds.

OCCUPATION (a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Green City Mo.

NAME OF FATHER McDole

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known

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) George H. Maloy

(ADDRESS) Hannibal Mo.

Filed Dec 27, 1911 J. H. Yause REGISTRAR

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

(Signed) A. H. Heavensridges M. D. Dec 21, 1911 (Address) 244 Madison

* 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 River Side DATE OF BURIAL Dec 24, 1911

UNDERTAKER W. M. Smith ADDRESS Hannibal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

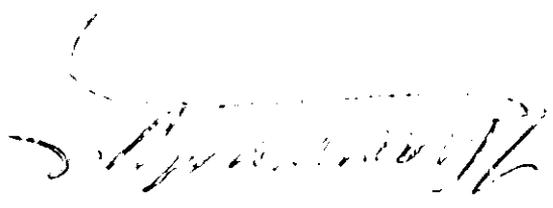
Revised United States Standard Certificate of Death

[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*, *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 septichaemia," "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.)



HUGH STEPHENS, JEFFERSON CITY.



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Marion

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

Township _____

Registration District No. 547

File No. _____

or Village _____

Primary Registration District No. 3029

Registered No. 328

or City Hannibal (NO. 217 Jordan St. 6 Ward)

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

FULL NAME Rachel M Maloy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Dec 20, 1911
(Month) (Day) (Year)

DATE OF BIRTH Mar 10, 1856
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Dec 13, 1911, to Dec 20, 1911, that I last saw her live on Dec 20, 1911, and that death occurred, on the date stated above, at 12²⁵ p

AGE 56 yrs. 9 mos. 10 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 Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Paralysis
acute ascending
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Greentons

Contributory (SECONDARY) _____

NAME OF FATHER Not known

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known

Signed P. J. McCarveridge M.D.
Dec 20, 1911 (Address) 244 Market St

MAIDEN NAME OF MOTHER "

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) George W Maloy

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

(ADDRESS) Hannibal Mo

Former or usual residence _____

Filed Dec 21 1911 W. H. House

PLACE OF BURIAL OR REMOVAL Riverside DATE OF BURIAL Dec 24 1911

REGISTRAR _____

UNDERTAKER Wm M Smith ADDRESS Hannibal

DEC 21 1911

Revised United States Standard Certificate of Death

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

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42031
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