

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty MadawayTownship Madaway

Village \_\_\_\_\_

City Beard (NO. \_\_\_\_\_)Registration District No. 618File No. 42187Primary Registration District No. 5820

Registered No. \_\_\_\_\_

St.: \_\_\_\_\_ Ward)

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

FULL NAME Rachel Johnston

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) WidowDATE OF BIRTH Feb 4, 1872  
(Month) (Day) (Year)AGE 77 yrs. 9 mos. 18 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?OCCUPATION (a) Trade, profession, or particular kind of work Housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_BIRTHPLACE (City or town, State or foreign country) Ross Co OhioPARENTS NAME OF FATHER Henry JonesBIRTHPLACE OF FATHER (City or town, State or foreign country) Name of town Unknown OhioMAIDEN NAME OF MOTHER Rachel JohnstonBIRTHPLACE OF MOTHER (City or town, State or foreign country) Name of town Unknown Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Nicholas(ADDRESS) Maupelle Mo.Filed Dec. 28, 1911, Old News

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 22, 1917  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec 19, 1911, to Dec 18, 1911, that I last saw her alive on Dec 18, 1911, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH\* was as follows:

82A Paralysis  
87D(Duration) 66 yrs. 10 mos. 10 ds.Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. D. Waller M. D.  
Dec 22, 1911 (Address) Burlington, 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 Ohio Semitery DATE OF BURIAL Dec 24, 1911UNDERTAKER T. E. Foye ADDRESS Beard Mo

PLACE OF DEATH

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

(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 \_\_\_\_\_  
 (Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ 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 \_\_\_\_\_

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (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.  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 (SECONDARY)

(Signed) \_\_\_\_\_ (Address) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\*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 \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

## PLACE OF DEATH

County NodawayTownship Nodaway

Village \_\_\_\_\_

or \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

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 DEATH

Registration District No. 618

File No. \_\_\_\_\_

Primary Registration District No. 5820

Registered No. \_\_\_\_\_

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME Rachel Johnston

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow  
(If wife the word)DATE OF BIRTH Feb. 4, 1832  
(Month) (Day) (Year)AGE 79 yrs. 9 mos. 18 ds. If LESS than 1 day, hrs. or min.OCCUPATION (a) Trade, profession, or particular kind of work House Keeper  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_BIRTHPLACE (City or town, State or foreign country) Boss Co., OhioNAME OF FATHER Henry JonesBIRTHPLACE OF FATHER (City or town, State or foreign country) OhioMAIDEN NAME OF MOTHER Rachel CookerBIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Nicholas(ADDRESS) Maryville, Mo.Filed Dec 24, 1911 C. L. Grant REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 22, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec. 17, 1911, to Dec. 22, 1911, that I last saw her alive on Dec. 18, 1911, and that death occurred, on the date stated above, at 11A, m.The CAUSE OF DEATH\* was as follows:  
Paralysis, caused by  
stroke from on train(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. E. Wallace M. D.  
Dec. 23, 1911 (Address) Burlington, 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 Ohio Cemetery DATE OF BURIAL Dec. 24, 1911UNDERTAKER T. E. Fordyce ADDRESS Burl. Jc. 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]

**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.)

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