

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

PLACE OF DEATH
County Sullivan
Township Clay
or McDonough
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 853 File No. 43688 9
Primary Registration District No. 6116B Registered No. 9

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

FULL NAME Dead Insurance

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec 24, 1911
(Month) (Day) (Year)

AGE _____ 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) War Newton

PARENTS
NAME OF FATHER Bert Hardie
BIRTHPLACE OF FATHER (City or town, State or foreign country) Leura, S
MAIDEN NAME OF MOTHER Rosa Webb
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sullivan Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Hardie
(ADDRESS) P.F.D. Harris

Filed Dec 26 1911 O.W. Widney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 25, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from at Birth, 1911, that I last saw her alive on Dec 24, 1911, and that death occurred, on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
15 1/2
15 1/2
Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____, 1911 (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 At Home DATE OF BURIAL Dec 26, 1911
UNDERTAKER No Undertaker ADDRESS _____

(name origin; "Cancer" is
use of "Tumor" for malignant
; *Whooping cough*; *Chronic valvular*
interstitial nephritis, etc. The
ary or intercurrent) affection need
important. Example: *Measles* (dis-
29 ds.; *Bronchopneumonia* (sec-
ter report mere symptoms or ter-
ugh as "Asthenia," "Anaemia"
), "Atrophy," "Collapse," "Coma,"
ity" ("Congenital," "Senile," etc.),
on," "Heart failure," "Haemor-
"Marasmus," "Old age," "Shock,"
is," etc., when a definite disease
s the cause. Always qualify all
om childbirth or miscarriage, as
nia," "PUERPERAL peritonitis," etc.
h surgical operation was under-
ATHS state MEANS OF INJURY and
SUCIDAL, OR HOMICIDAL, or as
possible to determine definitely.
drowning; *Struck by railway*
over wound of head—homicide;
acid—probably suicide. The na-
s fracture of skull; and conse-
etanus) may be stated under the
" (Recommendations on state-
th approved by Committee on
American Medical Association.)



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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County SullivanTownship Clay

or Village

or City

Registration District No. 853

File No.

Primary Registration District No. 6116 B

Registered No.

9

St. _____ Ward _____

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

FULL NAME

Died unnamed

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

Dec. 24, 1911
(Month) (Day) (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)

near Newtown

PARENTS

NAME OF FATHER

Bert HaddenBIRTHPLACE OF FATHER
(City or town, State or foreign country)Tenn.

MAIDEN NAME OF MOTHER

Gosa WebbBIRTHPLACE OF MOTHER
(City or town, State or foreign country)Sullivan Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Hadden(ADDRESS) P. F. W. HarrisFiled 7/17 9 5 1912 A. N. Hudner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec. 25, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from

Birth, 1911that I last saw her alive on Dec. 24, 1911,and that death occurred, on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Premature Birth

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

Contributory

(SECONDARY)

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

(Signed) A. N. Hudner M. D.1911 (Address) Newtown, 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

At Home

DATE OF BURIAL

Dec. 25, 1911

UNDERTAKER

No undertaker

ADDRESS

Original file, date 12 26 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, 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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