

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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 Cedar
Township Sum or Village Stockton City Stockton (NO. _____) St. _____ Ward _____
Registration District No. 165 File No. 525
Primary Registration District No. 4097 Registered No. 7
FULL NAME Nancy Caroline Craig
[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widowed</u>	DATE OF DEATH <u>January 26</u> , 19 <u>12</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Dec 25</u> , 18 <u>43</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>January 12th</u> , 19 <u>12</u> , to <u>January 26th</u> , 19 <u>12</u> , that I last saw her alive on <u>January 26th</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:	
AGE <u>68</u> yrs. <u>1</u> mos. <u>1</u> 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) <u>9-0</u>			The CAUSE OF DEATH* was as follows: <u>Bronchitis</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Hermitage, Henry Co Mo</u>			<u>131</u> <u>106D</u> (Duration) _____ yrs. _____ mos. <u>14</u> ds.	
PARENTS	NAME OF FATHER <u>Unknown</u>		Contributory <u>Chronic Nephritis</u> (SECONDARY)	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>		(Duration) _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Frankie Norman</u>		(Signed) <u>R. H. Boyer</u> M. D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Henry Co Mo.</u>		<u>Jan 27</u> , 19 <u>12</u> (Address) <u>Stockton Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>N. E. Craig</u> (ADDRESS) <u>Stockton Mo</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
Filed <u>Jan 27</u> , 19 <u>12</u> <u>E. Smith</u> REGISTRAR			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>Stockton Mo</u> DATE OF BURIAL <u>Jan 28</u> , 19 <u>12</u> ADDRESS <u>Stockton Mo</u>	
			UNDERTAKER <u>H. Smith & Son</u>	

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.)



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

PLACE OF DEATH Cedar
 County Cedar
 Town or Village or City Stockton (NO. _____) St.: _____ Ward _____
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Registration District No. 165 File No. 525
 Primary Registration District No. 4097 Registered No. 7
 FULL NAME Nancy Caroline Craig
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>f.</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>wid.</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Dec 25</u> , 18 <u>93</u> <small>(Month) (Day) (Year)</small>		
AGE <u>68</u> yrs. <u>1</u> mos. <u>1</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Hermitage Mo</u>		
PARENTS	NAME OF FATHER <u>Un</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Un</u>	
	MAIDEN NAME OF MOTHER <u>Franklin Dorman</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Nianny Co Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 26, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 17, 1912, to Jan 26, 1912, that I last saw him alive on Jan 26, 1912, and that death occurred, on the date stated above, at 8:30 m.
 The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
 (Duration) ___ yrs. ___ mos. 14 ds.
 Contributory (SECONDARY) Chronic nephritis
 (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) R. A. Brown M. D.
Jan 27, 1912 (Address) Stockton 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 Stockton Mo. DATE OF BURIAL Jan 28, 1912
 UNDERTAKER F. N. Smith & son ADDRESS Stockton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) M. E. Craig
 (ADDRESS) Stockton Mo
 Filed Jan 27, 1912 by E. S. Smith REGISTRAR

JAN * 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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