

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

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 Snow
 Township Acadia Registration District No. 391 File No. 1080
 or Acadia Primary Registration District No. 5346a Registered No. 2
 Village Acadia
 or
 City _____ (NO. _____ St. _____ Ward _____)

FULL NAME Mrs. C. A. Pilley

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Widow</u> OR DIVORCED (Write the word)
DATE OF BIRTH <u>July 21, 1853</u> (Month) (Day) (Year)		
AGE <u>78</u> yrs. <u>x</u> mos. <u>2</u> ds.		IF LESS than 1 day, <u>hrs.</u> or <u>min.</u>
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>None 0-0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Lewisburg, York Co. Pa.</u>		
PARENTS	NAME OF FATHER <u>Mrs. M. C. Hammond</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Pa. Co. Pa.</u>	
	MAIDEN NAME OF MOTHER <u>Unknown</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 2, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 31, 1911, to Jan 2, 1912, that I last saw her alive on Jan 2, 1912, and that death occurred, on the date stated above, at 9:56 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
107A
112

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

Contributory arth. m.
(SECONDARY) (Duration) x yrs. x mos. x ds.

(Signed) R. W. Gay M. D.
Jan 3, 1912 (Address) Fronton, Mo.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. Hammond
 (ADDRESS) St. Loto, Mo.

Filed Jan 3rd 1912 R. W. Gay
 by Hannie Walker 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>St. Louis, Mo.</u>	DATE OF BURIAL <u>Jan 4, 1912</u>
UNDERTAKER <u>A. Reppin & Son</u>	ADDRESS <u>Fronton, Mo</u>

Dept.

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 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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PLACE OF DEATH

County Iron
Township Arcadia
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 391 File No. 1080
Primary Registration District No. 5546a Registered No. 2

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

FULL NAME Mr. C. A. Pilley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W. SINGLE wd.
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH July 21, 1893
(Month) (Day) (Year)
AGE 28 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH _____, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Dec 31, 1911, to Jan 2, 1912, that I last saw deceased on Jan 2, 1912, and that death occurred, on the date stated above, at 956a m. The CAUSE OF DEATH* was as follows:
Bronche Pneumonia
X

BIRTHPLACE (City or town, State or foreign country) Lewisburg, Pa.
PARENTS
NAME OF FATHER Major N. Wood
BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa.
MAIDEN NAME OF MOTHER unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. W. Gay M. D.
Jan 3, 1912 (Address) Franklin
*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Oswald
(ADDRESS) De Soto Mo.

PLACE OF BURIAL OR REMOVAL St Louis Mo DATE OF BURIAL Jan 4, 1912

Filed Jan 3, 1912 by R. W. Gay REGISTRAR
Nannie Walker Deput

UNDERTAKER A. Beckin & Son ADDRESS Franklin

JAN 7 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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