

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 Monroe
Township Upper Lutre or Village _____
City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 595 File No. 2068
Primary Registration District No. 5791 Registered No. 2

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

FULL NAME Virginia May Kay

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH	
			<u>Jan. 10, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from	
_____ (Month) _____ (Day) _____ (Year)			<u>Jan 2, 1912</u> to <u>Jan 10th, 1912</u>	
AGE			that I last saw her alive on <u>Jan 8th, 1912</u>	
_____ yrs. _____ mos. _____ ds.			and that death occurred, on the date stated above, at <u>10</u> m.	
OCCUPATION			The CAUSE OF DEATH* was as follows:	
(a) Trade, profession, or particular kind of work _____			<u>2311</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>0-0</u>			<u>Pulmonary Tuberculosis</u>	
BIRTHPLACE (City or town, State or foreign country)			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER		Contributory <u>Heart failure</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		(Duration) _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER		(Signed) <u>Geo. B. Russell</u> M. D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)		_____ 191____ (Address) <u>Wallsville Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
(Informant) _____			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
(ADDRESS) _____			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
Filed <u>Jan 12, 1912</u> <u>H. A. Dixon</u> REGISTRAR			Where was disease contracted If not at place of death? _____	
			Former or usual residence _____	
			PLACE OF BURIAL OR REMOVAL <u>St Louis</u> DATE OF BURIAL <u>Jan 12, 1912</u>	
			UNDERTAKER <u>F. W. Kubie</u> ADDRESS <u>Wallsville Mo</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.)



WABLE 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

County Montgomery
Township Upper Louisa
or
Village
or
City

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

Registration District No. 5-95 File No. 2068
Primary Registration District No. 5-791 Registered No. 2
St.: _____ Ward _____

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

FULL NAME Virginia May 74 yrs.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Aug. 10th 1880</u> (Month) (Day) (Year)		
AGE <u>31^{1/2} yrs. 4^{1/2} mos. 24^{1/2} ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.
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>*</u>		

DATE OF DEATH Jan 10, 1912
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Jan 2, 1912, to Jan 10, 1912
that I last saw her alive on Jan 8, 1912
and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

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

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

PARENTS

NAME OF FATHER <u>Blues Deane</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St. Louis, Mo.</u>
MAIDEN NAME OF MOTHER <u>Agnes Bedford</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scotland</u>

Contributory Heart failure
(SECONDARY)

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

(Signed) G. M. Presnell M. D.
Jan 10, 1912 Address Wallerly, 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) X Henry Talo

(ADDRESS) X Wallouth, Mo.

Filed Jan 15, 1912 G. D. Moore 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 St. Louis DATE OF BURIAL Jan 12, 1912

UNDERTAKER F. W. Kuhue ADDRESS Wallerly, Mo.

Original file, date Jan 10, 1912 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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