

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Boone</i>	Registration District No.	<i>77</i>	File No.	<i>1 4206</i>
Township or Village	<i>MO</i>	Primary Registration District No.	<del>4047</del> <i>57156</i>	Registered No.	<i>3</i>
City	(NO. _____)	Ward		[If death occurred in a hospital or institution, give its NAME instead of street and number]	
FULL NAME			<i>Mary white</i>		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>Female</i>	<i>Negro</i>	<i>married</i>	<i>2</i>	<i>21</i>	<i>1912</i>
DATE OF BIRTH			(Month) (Day) (Year)		
<i>No Data</i> , <i>1849</i>					
AGE			IF LESS than 1 day, ____ hrs. or ____ min.?		
<i>63</i> yrs. ____ mos. ____ ds.					
OCCUPATION			HEREBY CERTIFY, that I attended deceased from		
(a) Trade, profession, or particular kind of work <i>House wife</i>			<i>Feb 15</i> , 1912, to <i>Feb 21</i> , 1912,		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>9-0</i>			that I last saw her alive on <i>Feb 21</i> , 1912,		
BIRTHPLACE (City or town, State or foreign country)			and that death occurred, on the date stated above, at <i>4 P. M.</i>		
<i>Providence Mo</i>			The CAUSE OF DEATH* was as follows:		
NAME OF FATHER			<i>Peritonitis</i>		
<i>Robt James</i>			<i>194 B</i>		
BIRTHPLACE OF FATHER (City or town, State or foreign country)			(Duration) yrs. ____ mos. ____ ds.		
<i>No Data</i>			<i>9</i> - <i>0</i> - <i>0</i>		
MAIDEN NAME OF MOTHER			Contributory (SECONDARY)		
<i>No Data</i>			(Duration) yrs. ____ mos. ____ ds.		
BIRTHPLACE OF MOTHER (City or town, State or foreign country)			(Signed) <i>F B Williams</i> M. D.		
<i>No Data</i>			<i>2-24</i> , 1912 (Address) <i>M C Bassie</i>		
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) <i>Adella White</i>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
(ADDRESS) <i>M C Bassie</i>			At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.		
Filed <i>2-24</i> , 1912, <i>F B Williams</i> REGISTRAR			Where was disease contracted if not at place of death?		
			Former or usual residence		
			PLACE OF BURIAL OR REMOVAL		
			<i>Mt Celestial Cemetery</i>		
			DATE OF BURIAL		
			<i>2-24</i> , 1912		
			UNDERTAKER		
			<i>Park Lur. Co</i>		
			ADDRESS		
			<i>Columbids</i>		

# 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.)



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

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

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

Registration District No. 774045 File No. 4206  
Primary Registration District No. 5157 Registered No. 3

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

FULL NAME

Mary White

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Black SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH 2 - 21, 1912  
(Month) (Day) (Year)

DATE OF BIRTH no date, 1849  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 15, 1912, to Feb 21, 1912; that I last saw her alive on Feb 21, 1912, and that death occurred, on the date stated above, at 4 P m.

AGE 63 yrs. 0 mos. 0 ds. IF LESS than 1 day, 0 hrs. or 0 min.

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

Perlonitic Traumatic  
accidental, lifting tub or injury  
by washboard (Duration) 9 yrs. 0 mos. 0 ds.  
Contributory \_\_\_\_\_  
(SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

NAME OF FATHER Robt. James

BIRTHPLACE OF FATHER (City or town, State or foreign country) no data

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

(Signed) F. B. Williamson, M. D.  
4/10, 1912 (Address) McBaine

\*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) A. della White

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(ADDRESS) McBaine

Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

Filed 4/10, 1912 F. B. Williamson REGISTRAR

PLACE OF BURIAL OR REMOVAL Mt. Celestia Cem DATE OF BURIAL 2-24, 1912

UNDERTAKER Park Fur. Co. ADDRESS Columbia

Original file, date FEB 24, 1912 All information called for must be written on this Supplementary Certificate.

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