

MARGIN RESERVED FOR BINDING

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 Clackson
Township _____ Registration District No. 207 File No. 4594
or Village _____ Primary Registration District No. 4175 Registered No. 197
or City Plattsburg (NO. _____) St. _____ Ward _____
FULL NAME Rebecca Satherine Smith
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH August 5th 1832
(Month) (Day) (Year)
AGE 79 yrs. 6 mos. 2 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0
BIRTHPLACE (City or town, State or foreign country) North Carolina
PARENTS NAME OF FATHER Daniel Albright
BIRTHPLACE OF FATHER (City or town, State or foreign country) North Carolina
MAIDEN NAME OF MOTHER Holt
BIRTHPLACE OF MOTHER (City or town, State or foreign country) North Carolina

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 7th 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Feb 1st 1912, to Feb 7th 1912, that I last saw her alive on Feb 6th 1912, and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Concussion
(Lapar)
1861
1908
Contributory Fracture neck of femur
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Frank Hamilton M. D. (Address) Plattsburg
*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 Plattsburg DATE OF BURIAL Feb 9th 1912
UNDERTAKER M. W. Thompson ADDRESS Plattsburg

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. O. R. Smith
(ADDRESS) 324 Franklin St. Plattsburg
Filed Feb 8th 1912 Frank Hamilton REGISTRAR

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.)



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PLACE OF DEATH

County

Clinton

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

Township

or Village

City

Plattsburg

Registration District No.

Primary Registration District No.

207

4125

File No.

Registered No.

4594

4

St. Ward

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

FULL NAME

Rebecca Catherine Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *F* COLOR OR RACE *w* SINGLE MARRIED WIDOWED OR DIVORCED *wid*
(Write the word)

DATE OF DEATH *Feb 7*, 191*2*
(Month) (Day) (Year)

DATE OF BIRTH *Aug 5*, 1832
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Jan 3*, 1912, to *Feb 7*, 1912, that I last saw her alive on *Feb 6*, 1912, and that death occurred, on the date stated above, at *11 P.* m.

AGE *79* yrs. *6* mos. *2* ds.
If LESS than 1 day, hrs. or 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)

Supremia (Labar)

BIRTHPLACE (City or town, State or foreign country)

(Duration) yrs. mos. ds.

NAME OF FATHER *Daniel Albright*

Contributory *Fracture neck of femur caused by falling on icy walk in kitchen*

BIRTHPLACE OF FATHER (City or town, State or foreign country)

(Signed) *Frank Hamilton* M. D.
Feb 8th, 1912 (Address) *Plattsburg*

MAIDEN NAME OF MOTHER *Haley*

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant) *Jo K. Smith*

Where was disease contracted If not at place of death?

(ADDRESS) *234 Franklin Chicago Ill*

Former or usual residence.

File *Feb 8th* 1912 *Frank Hamilton* REGISTRAR

PLACE OF BURIAL OR REMOVAL *Lathrop* DATE OF BURIAL *2/9*, 1912

UNDERTAKER *W. W. Thompson* ADDRESS *Plattsburg*

FEB

Original file, date _____, 19_____

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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