

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 Greene
Township Center
or
Village
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 3208 File No. 4926
Primary Registration District No. 5493 Registered No. 9 1

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

FULL NAME Hannah Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Lady COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF DEATH February 11, 1912
(Month) (Day) (Year)

DATE OF BIRTH Oct. 28, 1835
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb-9, 1912, to Feb-11, 1912, that I last saw her alive on 10, 1912,

AGE 76 yrs. 3 mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 30 a.m.
The CAUSE OF DEATH* was as follows:

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

Apoplexy
4 27 (Duration) ___ yrs. ___ mos. 2 ds.

BIRTHPLACE (City or town, State or foreign country) Green Cy, Tenn.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER James Catter

(Signed) J. M. Clark M. D.
Feb-11, 1912 (Address) Bou Darc md

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

MAIDEN NAME OF MOTHER Mc Niece

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

*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

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

(Informant) John Catter
(ADDRESS) Ashgrove Mo.

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

Filed Feb 12, 1912, S. F. Freeman REGISTRAR

PLACE OF BURIAL OR REMOVAL Joshua Chapple DATE OF BURIAL Feb 12, 1912

UNDERTAKER W. E. Redfean ADDRESS Bou Darc md

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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PLACE OF DEATH

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

County Greene
Township Center
or
Village Bois d'Arc
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 316 File No. 4926
Primary Registration District No. ~~315~~ Registered No. 221

FULL NAME Hannah Johnson

(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 (Write the word) Married
DATE OF BIRTH October 28, 1955
(Month) (Day) (Year)
AGE 26 yrs. 3 mos. 14 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work domestic housework a poplery
(b) General nature of industry, business, or establishment in which employed (or employer) industries

BIRTHPLACE
(City or town, State or foreign country) Greene Co Tenn

PARENTS
NAME OF FATHER James Cotter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
MAIDEN NAME OF MOTHER McKille
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Cotter
(ADDRESS) Ashtown Mo

Filed Feb 12 1922 Bois d'Arc
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 11th, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 9th, 1922 to Feb 11th, 1922
that I last saw her alive on Feb 10th, 1922
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:

grippe
grippe
(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. N. Clark M. D.
Feb 11th 1922 (Address) Bois d'Arc 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 Johns Church DATE OF BURIAL Feb 12 1922
UNDERTAKER W. E. Redfern ADDRESS Bois d'Arc Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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