

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH			
County	<i>Merced</i>		Registration District No.	<i>559</i>	File No.	<i>6006</i>
Township or Village	<i>Medicine</i>		Primary Registration District No.	<i>5753</i>	Registered No.	<i>2</i>
City	(NO. _____)	St.	(Ward _____)	[If death occurred in a hospital or institution, give its NAME instead of street and number]		
FULL NAME			<i>Sarah Jane Loveland</i>			
PERSONAL AND STATISTICAL PARTICULARS			1 MEDICAL CERTIFICATE OF DEATH			
SEX	COLOR OR RACE	SINGLE MARRIED <input checked="" type="checkbox"/> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH			
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>Feb. 3</i> , 191 <i>2</i> (Month) (Day) (Year)			
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from			
<i>Dec. 31</i> , 18 <i>48</i> (Month) (Day) (Year)			<i>Dec 17</i> , 1907, to <i>Jan 24</i> , 1912			
AGE			that I last saw her alive on <i>Jan 24</i> , 1912			
<i>66</i> yrs. <i>1</i> mos. <i>3</i> ds.			and that death occurred, on the date stated above, at <i>9:20</i> a.m.			
OCCUPATION (a) Trade, profession, or particular kind of work			The CAUSE OF DEATH* was as follows:			
<i>Home-wife</i>			<i>Paralysis</i>			
(b) General nature of industry, business, or establishment in which employed (or employer)			<i>81A</i> (Duration) _____ yrs. _____ mos. _____ ds.			
BIRTHPLACE (City or town, State or foreign country)			Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.			
<i>Merced Co Md.</i>			<i>None</i>			
PARENTS	NAME OF FATHER		[Signed] <i>C. L. McCaughan</i> M. D.			
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		<i>Feb 3</i> , 1912, (Address) <i>Spickard Md</i>			
	MAIDEN NAME OF MOTHER		*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)			
<i>Nancy McKern</i>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
<i>North Carolina</i>		Where was disease contracted if not at place of death? _____				
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <i>C. G. Loveland</i>						
(ADDRESS) <i>Spickard Md.</i>						
Filed <i>Feb 3</i> 191 <i>2</i>		REGISTRAR <i>C. L. McCaughan</i>				
PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL			
<i>Masonic Cemetery</i>			<i>Feb 4</i> , 191 <i>2</i>			
UNDERTAKER			ADDRESS			
<i>Perry Schooler</i>			<i>Spickard Md</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.)



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PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Mercer Registration District No. 559 File No. 60006
 Township Medicine Primary Registration District No. 5753 Registered No. 2
 City _____ (NO. _____ St. _____ Ward _____)

FULL NAME Sariat Jane Lovland

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH Dec 31 1845
 (Month) (Day) (Year)

AGE 66 yrs. 1 mos. 3 ds.
 IF LESS than 1 day, hrs. or min.

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

BIRTHPLACE (City or town, State or foreign country) Mercer Co Mo

PARENTS
 NAME OF FATHER Wm Keith
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Logan Co Ohio
 MAIDEN NAME OF MOTHER Agney McKern
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. C.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) C. A. Lovland

(ADDRESS) Speckard Mo

Filed Feb 3 1912 C. S. McClanahan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 3 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY; that I attended deceased from Dec 17 1917, to Jan 24 1912, that I last saw her alive on Jan 24 1912 and that death occurred, on the date stated above, at 9:20 a.m.

THE CAUSE OF DEATH* was as follows:
Paralysis Bulbar
 (Duration) abt 5 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) C. S. McClanahan M. D.
Dec 3 1912 (Address) Speckard 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 Masonic Cem DATE OF BURIAL Feb 4 1912
 UNDERTAKER Terry Scholer ADDRESS Speckard Mo

Revised United States Standard Certificate of Death

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

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