

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	<u>Salmon</u>		Registration District No.	<u>796</u>	File No.	<u>7701</u>
Township	<u>Marshall</u>		Primary Registration District No.	<u>6039</u>	Registered No.	<u>32</u>
or Village			City	(NO. _____) St. _____	Ward	
or City			FULL NAME <u>Marthay Jane Griffitts</u>			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH			
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Feb 27, 1912</u> (Month) (Day) (Year)			
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from			
<u>Feb 5, 1841</u> (Month) (Day) (Year)			<u>Feb 26, 1912, to Feb 26, 1912,</u>			
AGE			that I last saw her alive on <u>Feb 26, 1912,</u>			
<u>71</u> yrs. <u>0</u> mos. <u>22</u> ds.			and that death occurred, on the date stated above, at <u>5 a. m.</u>			
OCCUPATION			The CAUSE OF DEATH* was as follows:			
(a) Trade, profession, or particular kind of work <u>House Keeper</u>			<u>Indigestion of Stomach</u>			
(b) General nature of Industry, business, or establishment in which employed (or employer) _____			<u>&amp; Liver</u>			
BIRTHPLACE			<u>125 B. O. B.</u>			
(City or town, State or foreign country) <u>Ill. 9-33</u>			(Duration) _____ yrs. _____ mos. _____ ds.			
PARENTS	NAME OF FATHER		Contributory			
	<u>William Griffitts</u>		(SECONDARY)			
	BIRTHPLACE OF FATHER		(Duration) _____ yrs. _____ mos. _____ ds.			
	(City or town, State or foreign country) <u>Ill.</u>		(Signed) <u>J. E. Harris</u> M. D.			
MAIDEN NAME OF MOTHER		<u>Feb 28, 1912</u> (Address) <u>Marshall Mo</u>				
<u>Marthay J. Stanley</u>		*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		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
(City or town, State or foreign country) <u>Ill.</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>John J. Griffitts</u>						
(ADDRESS) <u>Marshall Mo</u>						
Filed <u>Feb 29, 1912</u>			PLACE OF BURIAL OR REMOVAL			
<u>A. C. Putnam</u> REGISTRAR			<u>Mt. Hope</u>			
			DATE OF BURIAL			
			<u>Feb 29, 1912</u>			
			UNDERTAKER			
			<u>Campbell &amp; Shaper</u>			
			ADDRESS			
			<u>Marshall Mo</u>			

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

# 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*, *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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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Saline  
 Township Marshall  
 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. 796 File No. 7701  
 Primary Registration District No. 6039 Registered No. 32

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

FULL NAME Martay Jane Griffitts

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb. 5, 1841  
(Month) (Day) (Year)

AGE 71 yrs. — 22 mos. — 22 ds.  
If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

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

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

PARENTS  
 NAME OF FATHER William Griffitts  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill  
 MAIDEN NAME OF MOTHER Margaret Stanley  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) John J. Griffitts  
 (ADDRESS) Marshall Mo

Filed Apr 12 1912 A. C. Putnam  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 27, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 26, 1912, to Feb 26, 1912,  
 that I last saw her alive on Feb 26, 1912,  
 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:  
Engestion of stomach's liver  
cause not known X  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) J. E. Harris, M. D.  
Marshall, 1912 (Address) Marshall 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 Mt. Hope DATE OF BURIAL 2/29, 1912  
 UNDERTAKER Campbell ADDRESS Marshall Mo

Original file, date FEB 29, 1912 All information called for must be written on this Supplementary Certificate.

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