

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 Washington
County Washington Registration District No. 1103 File No. 7978
Township Johnson or Village _____ Primary Registration District No. 6186 Registered No. 1
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Polly Littrell

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Widow</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>January 7th 1849</u> (Month) (Day) (Year)		
AGE <u>43</u> yrs. <u>0</u> mos. <u>17</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Gardener</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Schuyler Co. Ill.</u>		
PARENTS	NAME OF FATHER <u>Lewis Littrell</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>	
	MAIDEN NAME OF MOTHER <u>Mahaley Littrell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill.</u>	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>January 2nd 1912</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.	
The CAUSE OF DEATH* was as follows: <u>Consumption</u> <u>203A</u>	
Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>Robert Hall</u> Registrar <u>Feb 7th 1912</u> (Address) <u>Hillsboro Mo</u>	
*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 _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Littrell
(ADDRESS) Hillsboro Mo
Filed Feb 7th 1912 Robert Hill REGISTRAR

PLACE OF BURIAL OR REMOVAL Bright Green Yard DATE OF BURIAL 26th Jan 1912
UNDERTAKER Algie, Mo. ADDRESS Algie, Mo.
Phil. Norfheutt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

St. _____ Ward _____

City _____ (NO. _____)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE _____ MARRIED _____
WIDOWED _____ DIVORCED _____
(If fill the words)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds. or _____ day, _____ hrs. or _____ min. ?

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

BIRTHPLACE _____
(City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h _____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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

(Signed) _____ (Address) _____ 191____ M. D.

*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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(ADDRESS) _____

PLACES

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
_____	_____ 191____

UNDERTAKER _____ ADDRESS _____

Filed _____ 191____ REGISTRAR _____

PLACE OF DEATH

County

Washington

Township

Johnson

or

Village

City

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

1103

File No.

Primary Registration District No.

6186

Registered No.

1

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

FULL NAME

Polly Littrell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female	COLOR OR RACE white	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow
DATE OF BIRTH January 7 th 1849 (Month) (Day) (Year)		
AGE 63 yrs. 0 mos. 17 ds. if LESS than 1 day, ... hrs. or ... min.		

OCCUPATION
(a) Trade, profession, or particular kind of work
Housekeeper
Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)
Schuyler Co., Ill.

PARENTS	NAME OF FATHER Lewis Littrell
	BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
	MAIDEN NAME OF MOTHER Mary Litterell
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Littrell

(ADDRESS)

Hulsey Mo.

Filed

Feb 7, 1912

Robert Hall

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

January 24th 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Consumption
Tuberculosis of lungs

(Duration) 20 yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Robert Hall, Registrar
Feb 7, 1912 (Address) Hulsey 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

DATE OF BURIAL

Bryant Graveyard

26th Jan., 1912

UNDERTAKER

ADDRESS

algie mo
Phil. Nothcutt

algie mo.

Original file, date, 1912

All information called for must be written on this Supplementary Certificate.

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.

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.)

8161