

N. B.—Every item of information should be verbatim, as spelled. 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 Poek
Township Marion or ✓ Registration District No. 701 File No. 10558
Village _____ Primary Registration District No. 5930 Registered No. 7
City _____ (NO. _____) St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hannah C. Parrott

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Widowed</u>
DATE OF BIRTH <u>October 18, 1821</u> (Month) (Day) (Year)		
AGE <u>90 yrs. 4 mos. 19 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-19</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Dandridge, Tennessee</u>		
PARENTS	NAME OF FATHER <u>Hugh Tate</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tennessee</u>	
	MAIDEN NAME OF MOTHER <u>Rachel Doraty</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tennessee</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs A W Russell</u> (ADDRESS) <u>Balivar Mo</u>		
Filed <u>March 7, 1912</u> <u>W. D. Russell</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 7, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 6, 1912, to March 6, 1912, that I last saw her alive on March 6, 1912, and that death occurred, on the date stated above, at 10³⁰ p. m.

The CAUSE OF DEATH* was as follows:
108
Pneumonia
(Duration) yrs. mos. 2 ds.

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

(Signed) A. G. Mitchell M. D.
March 7, 1912 (Address) Bohler, 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 <u>Salem, Clayport</u>	DATE OF BURIAL <u>Mar 8, 1912</u>
UNDERTAKER <u>W. S. White</u>	ADDRESS <u>Bohler Mo.</u>

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.)



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

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

PLACE OF DEATH
County Oriskany
Township Marion
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 701 File No. 10553
Primary Registration District No. 5930 Registered No. 7

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

FULL NAME Ramona C. Parrott

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED 2nd
(Write the word)

DATE OF DEATH Mar 7, 1912
(Month) (Day) (Year)

DATE OF BIRTH Oct 18, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 6, 1912, to Mar 6, 1912, that I last saw her alive on Mar 6, 1912, and that death occurred, on the date stated above, at 1:30 p.m.

AGE 90 yrs. 4 mos. 19 ds. IF LESS than 1 day, hrs. or mins.

The CAUSE OF DEATH* was as follows:
Cerebrumonia
Lobar

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

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

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

NAME OF FATHER Hugh White

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

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

(Signed) X A. G. Mitchell M. D. May 29, 1912 (Address) Bolivar, Mo.

MAIDEN NAME OF MOTHER Rachel Doraty

*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) Tenn.

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) Mrs. A. M. Russell

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

(ADDRESS) Bolivar, Mo.

Former or usual residence _____

Filed May 29, 1912 W. S. White REGISTRAR

PLACE OF BURIAL OR REMOVAL Bolivar, Tenn. DATE OF BURIAL Mar 7, 1912

UNDERTAKER W. S. White ADDRESS Bolivar, Mo.

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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.)