

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

PLACE OF DEATH

County Franklin

Township _____

or

Village _____

or

City Clarksville

Registration District No. 675

File No. 3 14555

Primary Registration District No. 4409

Registered No. 109

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

FULL NAME Marie Corene Repton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Female

Black

Single

DATE OF BIRTH

Feb 4, 1893
(Month) (Day) (Year)

AGE

19 yrs. 2 mos. 11 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

House work

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

wages

BIRTHPLACE

(City or town, State or foreign country)

Missouri

NAME OF FATHER

Sam Repton

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Missouri

MAIDEN NAME OF MOTHER

Rose Hill

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam Repton

(ADDRESS)

Clarksville

Filed April 15, 1912

REGISTRAR

DATE OF DEATH

April 15, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 20, 1912, to April 15, 1912, that I last saw her alive on April 15, 1912, and that death occurred, on the date stated above, at 9:30 AM.

The CAUSE OF DEATH⁺ was as follows:

11A
107B
Lupus of Capillary Bronchitis
(Duration) yrs. mos. 11 ds.

Contributory (SECONDARY)

Capillary Bronchitis
(Duration) yrs. mos. 15 ds.

(Signed) E M Barclay M. D.
April 15, 1912 (Address) Clarksville 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

Clarksville

DATE OF BURIAL

4/18, 1912

UNDERTAKER

W L Duncan

ADDRESS

Clarksville

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, 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 septichaemia," "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.)



PLACE OF DEATH

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

Township _____

Registration District No. 685File No. 14555

Village _____

Primary Registration District No. 4409Registered No. 19City Clarksville (NO. _____)

St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)DATE OF BIRTH Feb 4, 1893
(Month) (Day) (Year)AGE 19 yrs. 2 mos. 11 ds. If LESS than 1 day, _____ hrs. or _____ min.?OCCUPATION (a) Trade, profession, or particular kind of work house work wages
(b) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE (City or town, State or foreign country) Mo.NAME OF FATHER Sam AytsonBIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.MAIDEN NAME OF MOTHER Grace HillBIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Aytson(ADDRESS) ClarksvilleFILED APR 15 1912 W. H. Inadway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 15, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mar 20, 1912, to Apr 15, 1912, that I last saw her alive on Apr 15, 1912, and that death occurred, on the date stated above, at 9:30 a
The CAUSE OF DEATH* was as follows:
Lagrippa & capillary bronchitisContributory Capillary bronchitis
(SECONDARY) (Duration) _____ yrs. _____ mos. 11 ds.(Signed) E. M. Boydlett M. D.
Apr 15 1912 (Address) Clarksville 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 Clarksville DATE OF BURIAL Apr 18, 1912UNDERTAKER W. C. Duncan ADDRESS Clarksville Mo.

Revised United States Standard Certificate of Death

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

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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.)