

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 Bellevue
 Township Bellevue
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 885 File No. 15999
 Primary Registration District No. 6127 Registered No. _____

FULL NAME Mary Ann Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>♀</u>	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>June 14, 1861</u> (Month) (Day) (Year)		
AGE <u>50 yrs. 8 mos. 24 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>H. Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Operative Bung Co L.C.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>9-0</u>		
PARENTS	NAME OF FATHER <u>John H. McCreath</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>S.C.</u>	
	MAIDEN NAME OF MOTHER <u>Martha Jane Smith</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>S.C.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 8, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1910, to March 8, 1912, that I last saw h. alive on " - 9 -, 1912, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Nephritis
130 A 01

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

Contributory 77 phad febr
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G H Counselor M. D.
3-8, 1912 (Address) Caledonia 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>Caledonia Mo</u>	DATE OF BURIAL <u>3-11</u> , 1912
UNDERTAKER <u>A R White</u>	ADDRESS <u>Cal. Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. Newton Smith
 (ADDRESS) Caledonia Mo

Filed 4-11, 1912 G H Counselor
 REGISTRAR

**MISSOURI STATE BOARD
BUREAU OF VITAL STA-
CERTIFICATE OF DEATH**

**Revised United States Standard Certificate
of Death**

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

PLACE OF DEATH

County _____
Township _____ or _____
Village _____ or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
AGE _____ yrs. _____ mos. _____ ds. _____
If LESS than 1 day, _____ hrs. _____ 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)

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

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

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR _____

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

I HEREBY CERTIFY, that I attended _____, 191____, to _____, that I last saw him _____ alive on _____; and that death occurred, on the date stated; The CAUSE OF DEATH* was as follows: _____

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

(Signed) _____ (Duration) _____ yrs. _____ (Address) _____

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTES, 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 _____

UNDERTAKER _____ ADDRESS _____

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 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Township Bellvue Registration District No. 885 File No. 15999
 or
 Village _____ Primary Registration District No. 6177 Registered No. _____
 or
 City _____ (NO. _____) St.: _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Mary Ann Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX Female Male
 COLOR OR RACE White Black Other
 SINGLE MARRIED Widowed Divorced
 DATE OF BIRTH Jan 14, 1861
 (Month) (Day) (Year)
 AGE 50 yrs. 8 mos. 24 ds.
 OCCUPATION (a) Trade, profession, or particular kind of work house wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 BIRTHPLACE (City or town, State or foreign country) South Carolina
 NAME OF FATHER John W. Chatham
 BIRTHPLACE OF FATHER (City or town, State or foreign country) S. C.
 MAIDEN NAME OF MOTHER Margha June Smith
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) S. C.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 8, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from April, 1910, to Mar 8, 1912,
 that I last saw her alive on Mar 8, 1912,
 and that death occurred, on the date stated above, at 8 A. M.
 THE CAUSE OF DEATH* was as follows:
nephritis
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory typhoid fever
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Geo. H. Edwards M. D.
Apr 12, 1912 (Address) Caledonia 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 Caledonia Mo. DATE OF BURIAL Apr 11, 1912
 UNDERTAKER H. R. White ADDRESS Caledonia Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Rev. Newton Smith
 (ADDRESS) Caledonia Mo
 FILED April 12, 1912 Geo. H. Edwards
 REGISTRAR

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*, *Sarcoma*, 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.)