

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.

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|--|---|--|--|
| PLACE OF DEATH County <u>Washington</u> | | MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH | |
| Township <u>Hannary</u> | Registration District No. <u>968</u> | File No. <u>16007</u> | |
| Village _____ | Primary Registration District No. <u>6184</u> | Registered No. <u>Five</u> | |
| City _____ (NO. _____) | St. _____ | Ward _____ | (If death occurred in a hospital or institution, give its NAME instead of street and number) |
| FULL NAME <u>Mrs Mable Hawkins</u> | | | |

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--|--|--|--|--|
| SEX <u>Female</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u> | DATE OF DEATH <u>April 1</u> , 191 <u>2</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>X</u> / <u>X</u> / <u>1</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>Feb 29</u> , 191 <u>2</u> , to <u>Mar 20</u> , 191 <u>2</u> , that I last saw her alive on <u>Feb 29</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>9.9</u> a.m. | |
| AGE <u>X</u> yrs. <u>1</u> mos. <u>1</u> ds. | | | The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> <u>and Throat</u> <u>23A</u> (Duration) <u>2</u> yrs. _____ mos. _____ ds. | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>9-0</u> | | | Contributory (Secondary) <u>8</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. J. Parker</u> M. D. <u>April 5th 1912</u> (Address) <u>Berryman Mo</u> | |
| BIRTHPLACE (City or town, State or foreign country) <u>near Palmer 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. | |
| PARENTS | NAME OF FATHER <u>W. P. Dicus</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>6</u> mos. <u>10</u> ds. In the <u>50</u> yrs. _____ mos. _____ ds. | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Palmer Mo</u> | | Where was disease contracted if not at place of death? Former or usual residence _____ | |
| | MAIDEN NAME OF MOTHER <u>Mable Dicus</u> | | PLACE OF BURIAL OR REMOVAL <u>Palmer Cemetery</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Sunlight Mo</u> | | DATE OF BURIAL <u>April 3</u> , 191 <u>2</u> | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. J. Parker</u> (ADDRESS) <u>Berryman</u> | | | UNDERTAKER <u>S. D. Campbell</u> | |
| Filed <u>4-9-2</u> 191 <u>2</u> <u>W. Mallow</u> REGISTRAR | | | ADDRESS <u>Palmer 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, 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, peritonacum*, 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.)



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

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PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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

Registration District No. 968 File No. 16007
Primary Registration District No. 6184 Registered No. 5

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

FULL NAME Mrs Mable Hawkin

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH Oct 27, 1877
(Month) (Day) (Year)
AGE 34 yrs. 6 mos. 8 ds. IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) near Palmer Mo.

PARENTS
NAME OF FATHER Mr. B. Dicus
BIRTHPLACE OF FATHER (City or town, State or foreign country) Palmer Mo.
MAIDEN NAME OF MOTHER Mable Baker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sunlight Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Parker
(ADDRESS) Berryman

Filed 4-9 1912 Sp. Mallard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 1st 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 29, 1912, to Mar. 20, 1912, that I last saw her alive on Feb. 29, 1912, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs and Throat.
(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. J. Parker M. D.
April 20, 1912 (Address) Berryman 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 1 yrs. 6 mos. 10 ds. In the 30 yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Palmer Cemetery DATE OF BURIAL April 3, 1912
UNDERTAKER S. D. Compton ADDRESS Palmer Mo.

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

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.)