

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 19195

PLACE OF DEATH

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

Registration District No. 826 File No. 12
Primary Registration District No. 6069 Registered No. 12

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

FULL NAME Lottie May Simmons

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White ~~MARRIED~~ ~~UNMARRIED~~ ~~OR UNMARRIED~~ (Write the word)

DATE OF BIRTH Dec 10, 1891
(Month) (Day) (Year)

AGE 21 yrs. 5 mos. 19 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Morley Mo

PARENTS
NAME OF FATHER Joseph Prance
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Viola May
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Prance
(ADDRESS) Cran Mo

Filed 5730 1912 R.C. Glenn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 29, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 20, 1912, to May 29, 1912
that I last saw her alive on May 29, 1912

and that death occurred, on the date stated above, at 108 m.
The CAUSE OF DEATH* was as follows:

Tuberculosis
V3P (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W.H. Westcott M. D.
1912 (Address) Cran 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 Morley DATE OF BURIAL May 30, 1912
UNDERTAKER J.S. Kissner ADDRESS Cran Mo

WRITE PLAIN UNFADING INK

N. B.—Every item of information should be carefully supplied. AGE shown as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important.

PLACE OF DEATH

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

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

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

(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 OR DIVORCED (Write the word)
	DATE OF BIRTH	
AGE	(Month) _____ (Day) _____ (Year) _____	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
 (a) Trade, profession, or business, or establishment in which employed (or employer)
 (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) _____, 191____ (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)
 (Signed) _____, 191____ (Address) _____ M. D.
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.

*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 _____, 191____

UNDERTAKER _____ ADDRESS _____

THIS IS A PUBLIC RECORD
 Information should be placed on ALL PUBLIC RECORDS
 be properly classified. Exact statement of OCCUPATION is v. important.

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

Item of information should be carefully supplied. If stated EXACTLY. PHYSICIANS should state DEATH in plain language so that it may be clearly understood. If death occurred in a hospital or institution, give its NAME instead of street and number.

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
 County Scott
 Township Sylvania Registration District No. 820 File No. 19105
 or
 Village _____ Primary Registration District No. 6067 Registered No. -12
 or
 City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Lottie May Simmons

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED m
(Write the word)

DATE OF BIRTH Dec. 10, 1891
(Month) (Day) (Year)

AGE 21 yrs. 5 mos. 19 ds.
If less than 1 day, hrs. or min.

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

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

PARENTS
 NAME OF FATHER Joseph Prance
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
 MAIDEN NAME OF MOTHER Egla May
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Robert Prance
 (ADDRESS) Oran Mo.

Filed 5/30 1912 R.C. Glenn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 29, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 20, 1912, to May 29, 1912, that I last saw her alive on May 29, 1912, and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:
Subcutis
Lobar X
 (Duration) _____ yrs. 10 mos. _____ ds.

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

(Signed) W.H. Wescoat M. D. X
5/30 1912 Address Oran, Mo. X

*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 Morley DATE OF BURIAL May 30, 1912
 UNDERTAKER T.S. Hiesey ADDRESS Oran Mo.

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, 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.)