

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  
County Newton  
Township Seneca or Village Seneca or City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registration District No. 611 File No. 20771  
Primary Registration District No. 4365 Registered No. \_\_\_\_\_

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

FULL NAME Mrs. Permelia Harriet Lenson

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> <small>(Write the word)</small>
DATE OF BIRTH <u>June 25</u> , 18 <u>42</u> <small>(Month) (Day) (Year)</small>		
AGE <u>69</u> yrs. <u>10</u> mos. <u>10</u> ds.		if LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Charleston Illinois</u>		
PARENTS	NAME OF FATHER <u>Thomas Daniel Curd</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kicholieville</u>	
	MAIDEN NAME OF MOTHER <u>Eveline Upton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Louisville Ky.</u>	

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH May 5, 1922  
(Month) (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 1:30 P.M.

The CAUSE OF DEATH\* was as follows:  
Likely some heart trouble - Died in my nurse.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory No Physician  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
Ken. May 5 1922 (Address) Seneca, 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>Seneca Cemetery</u>	DATE OF BURIAL <u>May 6, 1922</u>
UNDERTAKER <u>Soft Broe.</u>	ADDRESS <u>Seneca, Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Lieve Walker  
(ADDRESS) Seneca, Mo.  
Filed June 1, 1922 Don Kamphake  
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*, *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, peritonaeum*, 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.)



PLAINLY, WITH CARE & PENSIVE INK—THIS IS A PERMANENT RECORD.

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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 Newton  
Township \_\_\_\_\_  
or  
Village Seneca  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 611 File No. 20771  
Primary Registration District No. 4365 Registered No. 48

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

FULL NAME Mrs Permelia Harriet Lemon.

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>F.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>
DATE OF BIRTH <u>June 25</u> , 1 <u>842</u> <small>(Month) (Day) (Year)</small>		
AGE <u>69</u> yrs. <u>10</u> mos. <u>10</u> ds. <small>IF LESS than 1 day, ___ hrs. or ___ min.</small>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Charleston, Missouri</u>		
PARENTS	NAME OF FATHER <u>Thomas Gabriel Curd</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Nicholsville, Ky.</u>	
	MAIDEN NAME OF MOTHER <u>Esternie Upton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Louisville Ky.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Isaac Walker</u> (ADDRESS) <u>Seneca Mo.</u>		
Filed <u>July 8</u> 191 <u>2</u> by <u>W. M. Campbell</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>May 5</u> <small>(Month) (Day) (Year)</small>	
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 <u>1:30 P.M.</u>	
The CAUSE OF DEATH* was as follows: <u>Likely some heart trouble - Died in one minute. Have no way of knowing as there was no physician.</u> <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>	
Contributory <small>(SECONDARY)</small> <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>	
(Signed) <u>W. M. Campbell</u> M. D. <u>May 5</u> , 191 <u>2</u> (Address) <u>Seneca 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.	
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>Seneca Cem.</u>	DATE OF BURIAL <u>May 6</u> , 191 <u>2</u>
UNDERTAKER <u>Saft Bros.</u>	ADDRESS <u>Seneca Mo.</u>

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Association]

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