

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

PLACE OF DEATH

County Stone
Township Washington
or Village
or City (No. _____ St. _____ Ward _____)

Registration District No. 843 File No. 21992
Primary Registration District No. 6104 Registered No. 6

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

FULL NAME Eva Lois Evans

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 23, 1912
(Month) (Day) (Year)

AGE No yrs. No mos. 11 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(1) Trade, profession, or particular kind of work
(2) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE
City or town, State or foreign country) Stone Co. Mo

NAME OF FATHER Wm H. Evans

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Benton Co Ark.

MAIDEN NAME OF MOTHER Isabella Crouch

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Stone Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant) Willson H Evans
(ADDRESS) Galena Mo.

Filed June 6, 1912, J J McCard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 2, 1912
(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 _____ m.

The CAUSE OF DEATH* was as follows:
Caused is not know.
This baby was in usual health at night. Was found dead next morning.
(Duration) yrs. mos. ds.

Contributory 1900B
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____, 191____ (Address)

*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 I don't know

PLACE OF BURIAL OR REMOVAL Da DATE OF BURIAL _____ 191____

UNDERTAKER Know ADDRESS _____

CASES OF DEATH IN DEATH FORMS, SO FORTH, BY PROPERTY ORIGINATOR. EXTENT OF DEATH IN DEATH FORMS, SO FORTH, BY PROPERTY ORIGINATOR.

PLACE OF DEATH

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

County _____
 Township _____ or _____
 Village _____
 City _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

(If death occurred in hospital or institution give its NAME last 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 | (Month) _____ (Day) _____ (Year) _____ | |
| AGE | _____ yrs. _____ mos. _____ ds. | IF LESS than 1 day _____ hrs. or _____ 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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ 191? _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased fr _____, 191? _____, to _____, 191? _____ that I last saw h _____ alive on _____, 191? _____ and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

Contributory
 (SECONDARY) _____

(Signed) _____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____ (Duration) _____ yrs. _____ mos. _____

(Address) _____ 191? _____

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELING RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ In the _____ State _____ yrs. _____ mos. _____ ds. State _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ **DATE OF BURIAL OR REMOVAL** _____

UNDERTAKER _____ **ADDRESS** _____

Filed _____ 191? _____

REGISTRAR _____

REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.BUREAU OF VITAL STATISTICS.
CERTIFICATE OF DEATHPLACE OF DEATH
County Stone
Township Washington
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)Registration District No. 843 File No. 21992
Primary Registration District No. 6106 Registered No. 6[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]FULL NAME Eva Lois Evans

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH May 23, 1912
(Month) (Day) (Year)AGE _____ yrs. _____ mos. 11 ds. if LESS than 1 day, _____ hrs. or _____ 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) Stone Mo.NAME OF FATHER Wm H EvansBIRTHPLACE OF FATHER Beaumont Co. Ark.MAIDEN NAME OF MOTHER Isabella CrouitchBIRTHPLACE OF MOTHER Stone Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant William H. Evans
(ADDRESS) Galeva Mo.Filed June 4 1912 J. M. Cord
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 2, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 1912, to _____, 1912,
that I last saw him alive on _____, 1912,
and that death occurred, on the date stated above, at _____ m.The CAUSE OF DEATH* was as follows:
Cause is not known.
This baby was in usual health at night. Was found dead, next morning.Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. Kuceman M. D.
June 4 1912 (Address) _____

*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 Don't know DATE OF BURIAL _____ 1912UNDERTAKER Don't know ADDRESS Don't knowOriginal file, date JUN, 1912

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

MEDICAL CERTIFICATE OF DEATH
PERSONAL AND STATISTICAL PARTICULARS

FULL NAME

Standard Certificate of Death

Forms and American Association)

Statement of occupation.—Precise statement, so that the duties can be known, of the person, irrespective of sex, race, or color, who was the subject of the death. It should be a single word or phrase, such as *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*.

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.)