

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.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <i>female</i>	COLOR OR RACE <i>white</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>married</i>	DATE OF DEATH <i>7-24-1912</i> (Month) (Day) (Year)	
DATE OF BIRTH <i>July 24 1872</i> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
AGE <i>40</i> yrs. — mos. — ds.			that I last saw h _____ alive on _____, 191____,	
OCCUPATION (a) Trade, profession, or particular kind of work <i>House wife</i>			and that death occurred, on the date stated above, at <i>9 a.m.</i>	
(b) General nature of industry, business, or establishment in which employed (or employer) <i>9-0</i>			The CAUSE OF DEATH* was as follows: <i>Personal Convulsions from 6 a.m. to 9 a.m. = 7-24-12</i>	
BIRTHPLACE (City or town, State or foreign country) <i>Montgomery Co</i>			<i>Passed during journey & arrived</i> (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <i>James Moore</i>		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Virginia</i>		(Signed) <i>Edith E. Burton</i> M. D.	
	MAIDEN NAME OF MOTHER <i>Rosa Moore</i>		<i>7-24-1912</i> (Address) <i>Edith M.</i>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Virginia</i>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Albert M. Reynolds</i>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>5</i> yrs. — mos. — ds. In the State <i>40</i> yrs. — mos. — ds.	
(ADDRESS) <i>Whiteside Mo</i>			Where was disease contracted if not at place of death? <i>At place of death</i>	
Filed <i>July 24 '12</i> 191____			Former or usual residence _____	
REGISTRAR <i>C. E. Powell</i>			PLACE OF BURIAL OR REMOVAL <i>Mill Creek Cemetery</i>	
			DATE OF BURIAL <i>July 25 1912</i>	
			UNDERTAKER <i>Sarah Bushnell</i>	
			ADDRESS <i>Edith M.</i>	

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

23497 22501

File No.

Registration District No. *480*Primary Registration District No. *5649*

Registered No.

20

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

FULL NAME

Florence Reynolds

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

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)

Filed

191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

7-24-1912
 (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 *9 a.m.*

The CAUSE OF DEATH* was as follows:

Personal Convulsions from 6 a.m. to 9 a.m. = 7-24-12
Passed during journey & arrived (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

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

(Signed)

Edith E. Burton

M. D.

7-24-1912 (Address) *Edith M.*

*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 *5* yrs. — mos. — ds. In the State *40* yrs. — mos. — ds.Where was disease contracted if not at place of death? *At place of death*

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mill Creek Cemetery *July 25 1912*

UNDERTAKER

ADDRESS

Sarah Bushnell *Edith M.*

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*, *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

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

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

County Lincoln

Township Hurricane

or

Village

or

City

Registration District No. 486

Primary Registration District No. 5649

File No. 23497

Registered No. 20

St.: _____ Ward) _____

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

FULL NAME

Florence Reynolds

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 24, 1872
(Month) (Day) (Year)

AGE 40 yrs. mos. ds. If LESS than 1 day, hrs. or mins.

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) Montgomery Co.

NAME OF FATHER James Moore

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

MAIDEN NAME OF MOTHER Rosa Moore

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert M. Reynolds

(ADDRESS) Whiteside Mo.

Filed July 27, 1922 C. E. Powell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7-24, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1922, to _____, 1922, that I last saw him alive on _____, 1922.

that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Puerperal convulsions from 6 a. m. to 9 a. m. was dying when arrived

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

(Signed) Geo. C. Robertson M. D. 7-24 1922 (Address) Eolia 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 Mill Creek Cem. DATE OF BURIAL July 25, 1922

UNDERTAKER Gooch & Buchana ADDRESS Eolia Mo.

Revised United States Standard Certificate of Death

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

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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, 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.)