

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.

PLACE OF DEATH

County: Macoupin
 Township: _____
 or
 Village: Ethel
 or
 City: _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 531 File No. 23564-28004
 Primary Registration District No. 4317 Registered No. 36

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

FULL NAME Sarah E. VanSkike

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Dec 29, 1938
(Month) (Day) (Year)

AGE 14 yrs. 7 mos. 1 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
 (City or town, State or foreign country) Near Loganport, Ohio

PARENTS
 NAME OF FATHER J. R. Leffel
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
 MAIDEN NAME OF MOTHER Nancy J. Schellenger
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Waldron
 (ADDRESS) Ethel Mo.

Filed July 31, 1912 Francis W. Brown
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 31st, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from July 25, 1912, to July 31st, 1912, that I last saw her alive on July 31st, 1912, and that death occurred, on the date stated above, at 5 a.m.
 The CAUSE OF DEATH* was as follows:

Tuberculosis in the terminal stage; Cause of death.
23A
930A (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) W. A. Baldwin M. D.
July 31st 1912 (Address) Ethel, 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. 8 mos. _____ ds. In the 24 yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? Followed Bronchopneumonia

Former or usual residence at this place - Ethel Mo. 4 months ago.
Lafayette Mo.

PLACE OF BURIAL OR REMOVAL Ethel Cemetery DATE OF BURIAL August 1st 1912
 UNDERTAKER R. A. Mason ADDRESS Ethel, Mo.

PLACE OF DEATH

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (If file 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) _____

Filed _____, 191____, REGISTRAR _____

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

DATE OF DEATH _____ (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:

Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Address) _____ M. D. _____

* 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 _____

...LY, WITH UNFADING INK—THIS IS: 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.

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 Macon
Township _____
or
Village Ethel
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 531 File No. 23664
:Primary Registration District No. 4317 Registered No. 36

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

FULL NAME Sarah E. Van Skike

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED widowed WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH Dec. 29, 1888 (Month) (Day) (Year)
AGE 74 yrs. 7 mos. 1 ds. If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
BIRTHPLACE (City or town, State or foreign country) near Logan, Port Ohio

DATE OF DEATH July 31, 1912 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from July 25, 1912, to July 31, 1912, that I last saw her alive on July 31, 1912, and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis in the terminal stage of the lungs
(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER J. C. Poffel
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Nancy J. Shellenbarger
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

Contributory Myo Coarctal degeneration (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) N. C. Baldwin M. D. July 31, 1912 (Address) Ethel Mo.
*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) J. C. Waldron
(ADDRESS) Ethel Mo.
Filed July 31, 1912 W. Brown REGISTRAR

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 Ethel Cemetery DATE OF BURIAL Aug. 1, 1912
UNDERTAKER R. A. Mason ADDRESS Ethel Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. If SILVER ANNIVERSARY, or other special occasion, should be stated. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of BIRTHPLACE should be given. If the informant is not the informant, the name of the informant should be given.

SUPPLEMENTARY

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.)