

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 _____

Township _____ or _____ Registration District No. 791 File No. 25025

Village _____ or _____ Primary Registration District No. 1003 Registered No. 6665

City St. Louis, Mo. (NO. Mayfield Sanitarium St. Ward 25)

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

FULL NAME Lillie Jane Halley

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE - MARRIED - WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>July 30, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Jan 13, 1906</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>7/29</u> , 1912, to <u>7/30</u> , 1912, that I last saw her alive on <u>7/30</u> , 1912, and that death occurred, on the date stated above, at <u>1:30 p.m.</u>	
AGE <u>6 yrs. 6 mos. 17 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Infantile paralysis</u> <u>16</u> <u>986</u> <u>155 B</u> <u>146</u> (Duration) ___ yrs. ___ mos. ___ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>			Contributory <u>Wagoner</u> (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>			(Signed) <u>W H Mayfield</u> M. D. <u>July 30, 1912</u> (Address) <u>916 W. Taylor</u>	
PARENTS	NAME OF FATHER <u>Amos F. Halley</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Mary Alice Terhune</u>		At place of death ___ yrs. ___ mos. <u>1</u> ds. In the State ___ yrs. ___ mos. <u>1</u> ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>		Where was disease contracted if not at place of death? Former or usual residence <u>Whiteside Mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Amos F. Halley</u> (ADDRESS) <u>Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Whiteside Mo</u>	
FILED <u>JUL 30 1912</u> <u>Max B Starkloff</u> REGISTRAR			DATE OF BURIAL <u>July 30, 1912</u> ADDRESS <u>Wadkins La Grange Co 1024 Pendleton</u>	

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 lung*, *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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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. CAUSE 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 _____

Township _____

or

Village _____

or

City St. Louis (NO. Mayfield Sanitarium ST. Ward)

Registration District No. 791

File No. 25025

Primary Registration District No. 1003

Registered No. 6665

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

FULL NAME Lillie Jane Halley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

DATE OF DEATH July 30 1912
(Month) (Day) (Year)

DATE OF BIRTH Jan. 13 1906
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 7-29, 1912, to 7-30, 1912, that I last saw her alive on 7-30, 1912, and that death occurred, on the date stated above, at 1:30 a.m.

AGE 6 yrs. 6 mos. 17 ds. IF LESS than 1 day, hrs. or mins.

The CAUSE OF DEATH* was as follows:
necrosis of infection of maxillary tuberculation
(Duration) _____ yrs. _____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

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

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

NAME OF FATHER Amos F. Halley

(Signed) W. H. Mayfield M. D.
July 30, 1912 (Address) 920 N. Taylor

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

MAIDEN NAME OF MOTHER Margaret Kirchner

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) Amos F. Halley

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

(ADDRESS) Whiteside Mo.

Former or usual residence. _____

Filed SEP 10 1912 Max Starkloff REGISTRAR

PLACE OF BURIAL OR REMOVAL Whiteside Mo. DATE OF BURIAL July 30, 1912

UNDERTAKER Watkins L. And. Co. ADDRESS 1024 Pendleton Ave.

Original file, date JUL, 1912

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

Revised United States Standard Certificate of Death

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

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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.)