

PLACE OF DEATH

County FranklinTownship Union

or

Village _____

or

City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 282File No. 25885Primary Registration District No. 5701Registered No. 56

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

FULL NAME

Mattie Nilkerson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, 1_____, _____
(Month) (Day) (Year)

AGE

_____, _____, _____
yrs. mos. ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) - 9-0

BIRTHPLACE

(City or town, State or foreign country) Union

PARENTS

NAME OF FATHER

J. B. Singleton

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Union

MAIDEN NAME OF MOTHER

Adeline Goff

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Union

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. Singleton(ADDRESS) Campree MoFiled 8/20, 1912 W. M. Brogan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug 18, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug 18, 1912, to Aug 18, 1912, that I last saw her alive on Aug 18, 1912, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Malaria, only saw patient at noon ~~today~~, chills & sweats never relieved
38 (Duration) 2 yrs. _____ mos. _____ ds.

Contributory

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

(Signed) W. M. Brogan M. D.Aug 20, 1912 (Address) Campree 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

Milled

DATE OF BURIAL

Aug 19, 1912

UNDERTAKER

C. McBride

ADDRESS

Campree Mo

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*, *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.)



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

PLACE OF DEATH

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

Registration District No. 282 File No. 25885
 Primary Registration District No. 5401 Registered No. 56

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

FULL NAME Mattie Wilkerson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (If write the word)
 DATE OF BIRTH Don't know (Month) _____ (Day) _____ (Year) _____
 AGE Don't know yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

DATE OF DEATH Aug. 18, 1912
 (Month) _____ (Day) _____ (Year) _____
 I HEREBY CERTIFY, that I attended deceased from Aug. 18, 1912, to Aug. 18, 1912, that I last saw her alive on Aug. 18, 1912, and that death occurred, on the date stated above, at 5 p. m.

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 BIRTHPLACE (City or town, State or foreign country) Tenn.

The CAUSE OF DEATH* was as follows:
Chronic malaria, only saw patient at noon chill & collapse, never rallied. (Duration) _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ed Singleton
 (ADDRESS) Campbell Mo.
 Filed Aug 2 1912 by W. Brown REGISTRAR

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) C. W. Brown M. D. Aug. 20, 1912 (Address) Campbell 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 M. Gilead DATE OF BURIAL Aug. 19, 1912
 UNDERTAKER O. McPride ADDRESS Campbell Mo.

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.)