

## PLACE OF DEATH

County Dunklin  
 Township Boyd  
 or Boyd  
 Village Cardwell  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

Registration District No. 283 File No. 25894  
 Primary Registration District No. 4167 Registered No. 140

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

FULL NAME Ruth Muse

## PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Aug 27, 1912  
 (Month) (Day) (Year)

AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 yrs. mos. 4 ds.

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

BIRTHPLACE (City or town, State or foreign country) Cardwell MO

PARENTS  
 NAME OF FATHER Joel Muse  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Dunklin MO  
 MAIDEN NAME OF MOTHER Susan Crack  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Joel Muse  
 (ADDRESS) Cardwell MO

Filed Aug 31st 1912 Eli Back  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Aug 31st, 1912, to Aug 31st, 1912, that I last saw her alive on Aug 31st, 1912, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:  
Infection  
15 1 5 7  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. G. Brink M. D.  
no 70, 1912 (Address) Cardwell 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 Cardwell MO DATE OF BURIAL Sept 1st, 1912

UNDERTAKER J. R. Anderson ADDRESS Cardwell 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*, *Conductor*, *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.)

PLACE OF DEATH,

County Dunklin

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

Township \_\_\_\_\_

Registration District No. 283File No. 25894Village CardwellPrimary Registration District No. 4167Registered No. 140

City \_\_\_\_\_ (NO. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

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

FULL NAME

Ruth Muse

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)InfantFemale white

DATE OF BIRTH

Aug. 27, 1912  
(Month) (Day) (Year)

AGE

4 yrs. 4 mos. 4 ds.  
IF LESS than 1 day, hrs. or min.

OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Cardwell, Mo.

NAME OF FATHER

Joel Muse

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Dunklin Co. Mo.

MAIDEN NAME OF MOTHER

Edge Crast

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joel Muse(ADDRESS) Cardwell Mo.Filed 2-26 1912 Eli Back REGISTRAR

AUG

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug. 31, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Aug. 31, 1912, to Aug. 31, 1912that I last saw her alive on Aug. 31, 1912and that death occurred, on the date stated above, at 5p m.

The CAUSE OF DEATH\* was as follows:

Inanition  
Weakness(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory

(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. G. Bickett, M. D.  
9/1, 1912 (Address) Cardwell, 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

Pierce Graveyard

DATE OF BURIAL

Sept 1, 1912

UNDERTAKER

J. T. Anderson

ADDRESS

Cardwell Mo.

Original file, date \_\_\_\_\_, 19\_\_\_\_\_

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

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[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 "Asiheria," "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.)