

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 Green
Township ~~Green~~
or Village _____
or City Springfield

Registration District No. 318 File No. 26033
Primary Registration District No. 2001 Registered No. 436
St. 6 Ward _____

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

FULL NAME Theahey Burns

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE colored SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF BIRTH Jan 1 - 1892
(Month) (Day) (Year)

AGE 87 IF LESS than 1 day, ___ hrs. or ___ min.?
About yrs. mos. ds.

OCCUPATION (a) Trade, profession, or particular kind of work House Wife 92 A
(b) General nature of industry, business, or establishment in which employed (or employer) 9 - C. 89 B

BIRTHPLACE Tennessee
(City or town, State or foreign country)

PARENTS
NAME OF FATHER Isaac Hill
BIRTHPLACE OF FATHER unknown
MAIDEN NAME OF MOTHER Mollie Buttram
BIRTHPLACE OF MOTHER Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abie Adams

214 (ADDRESS) Franklin Ave
Filed Aug 15 1912 Wilbur Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8 - 9 - 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8 - 9 - 1912, to 8 - 14 - 1912
that I last saw her alive on 8 - 10 - 1912,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Paralysis

Contributory renal trouble
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) E. H. Adams M. D.
10/15 1912 (Address) 825 1/2 Pennell

*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 W. Hazelwood DATE OF BURIAL Aug. 16 1912
UNDERTAKER Dixon & Co 410 South St. ADDRESS _____

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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

X

PLACE OF DEATH

County Greene

Township _____

Registration District No. 318

File No. 26033

Village _____

Primary Registration District No. 2001

Registered No. 436

City Springfield

No. 814 Franklin St.

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

FULL NAME

Therby Burns

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Colored
SINGLE MARRIED widow
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Don't know
(Month) (Day) (Year)

AGE about 87 yrs. mos. ds.
- If LESS than 1 day, hrs. or min.

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) Tenn. Scott Co.

PARENTS NAME OF FATHER Isaac Hill

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

MAIDEN NAME OF MOTHER Mattie Buttram

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abie Adams

(ADDRESS) Franklin Ave,

Filed Aug 14 1912 Wilbur Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-14 1912
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from _____, 1912, to: 8-14, 1912
that I last saw him alive on 8-10, 1912

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:
Paralysis agitans

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

Contributory Metral Trouble
(SECONDARY)

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

(Signed) E. A. Harris M. D.
8/15 1912 (Address) 325 1/2 Bonwell

*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 Hazelwood

DATE OF BURIAL Aug. 16 1912

UNDERTAKER Parson and Co.

ADDRESS 410 South St,

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.)