

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 Washington
 Township Concord
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 886 File No. 28527
 Primary Registration District No. 6178 Registered No. 10 B

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

FULL NAME Mary Elizibeth Province

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>September 20, 1860</u> (Month) (Day) (Year)		
AGE <u>51</u> yrs. <u>10</u> mos. <u>22</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>		

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

PARENTS	NAME OF FATHER <u>Alfred Bradley</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn.</u>
	MAIDEN NAME OF MOTHER <u>Lavina Greene</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Walter Province
 (ADDRESS) Irondale, Mo.

Filed August 13, 1912 J. P. Hargain
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
August 12, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 3, 1912, to August 12, 1912, that I last saw her alive on August 12, 1912, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:

Gangrene of foot and limb
98B

(Duration) ___ yrs. ___ mos. 9 ds.

Contributory Unknown
 (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. P. Hargain M. D.
August 13, 1912 (Address) Irondale, 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
Hopewell, Mo.

DATE OF BURIAL
August 12, 1912
 UNDERTAKER
J. B. Boyer
 ADDRESS
Potosi, Mo.

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

PLACE OF DEATH

County _____ Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 City _____ (NO. _____ St. _____ Ward _____)
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RAGE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
-----	---------------	---

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 _____ (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:

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 _____

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

*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 _____

N. B.—Every item of information should be carefully supplied. All should be stated EXACTLY, PHASES of DEATH should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE IN INK. WRITING INK—THIS IS A PERMANENT RECORD

All information should be carefully supplied. NAME should be stated EXACTLY. PHYSICIANS should state MAUSE OF DEATH in plain language 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.

PLACE OF DEATH
County Washington
Township Concord
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 886 File No. 28527
Primary Registration District No. 6178 Registered No. 110 B.

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

FULL NAME Mary Elizabeth Province

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept. 20, 1860
(Month) (Day) (Year)

AGE 51 yrs. 10 mos. 22 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)

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

PARENTS NAME OF FATHER Alfred Bradley
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
MAIDEN NAME OF MOTHER Lagina Greene
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Walter Province
(ADDRESS) Irondale, Mo.

Filed Aug. 13, 1912 J. P. Hargain REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 12, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 3, 1912, to Aug. 12, 1912, that I last saw her alive on Aug. 12, 1912, and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:
Gangrene of foot & limb (unable to eld sleep)

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. P. Hargain M. D. Aug. 13, 1912 (Address) Irondale, 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 Hopewell, Mo. DATE OF BURIAL Aug. 12, 1912

UNDERTAKER J. B. Boyer ADDRESS Potosi, 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, 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.)