

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	Wayne		Registration District No.	894	File No. 28554
Township	Cowara		Primary Registration District No.	6196	Registered No.
or					
Village	Hiram				
or					
City	(NO.		St.		Ward)
FULL NAME			Rose Irene Barks		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
female	white	single	July 31, 1912 (Month) (Day) (Year)		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
May 23, 1912 (Month) (Day) (Year)			July 26, 1912, to July 31, 1912,		
AGE			that I last saw her alive on July 30, 1912,		
yrs. 2 mos. 9 ds.			and that death occurred, on the date stated above, at 4 m.		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work			Enterocolitis		
(b) General nature of industry, business, or establishment in which employed (or employer)			1198 158 (Duration) yrs. mos. ds.		
BIRTHPLACE			Contributory, birth fed		
(City or town, State or foreign country)			(SECONDARY) (Duration) yrs. mos. ds.		
Hiram Mo			(Signed) P. P. Burton M. D.		
PARENTS	NAME OF FATHER		Aug 1, 1912 (Address) Loundes Mo		
	BIRTHPLACE OF FATHER		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	BIRTHPLACE OF MOTHER		At place of death yrs. mos. ds. In the State yrs. mos. ds.		
		Julia Ann Barks		Where was disease contracted if not at place of death?	
		Ark.		Former or usual residence.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Julia Ann Barks					
(ADDRESS) Hiram Mo					
Filed Aug 1, 1912, P. P. Burton REGISTRAR					
PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL		
Hiram County			Aug 1, 1912		
UNDERTAKER			ADDRESS		
Mc Lane & Kinder			Loundes, 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*, *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.)



Not fully supplied, AGE should be stated EXACTLY. PHYSICIANS should state if 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 Wayne
Township Corban
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 894 File No. 283324
Primary Registration District No. 6196 Registered No. _____

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

FULL NAME Rose Irene Barks

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 23, 1912
(Month) (Day) (Year)

AGE 2 yrs. 9 mos. 9 ds. If LESS than 1 day, _____ hrs. or _____ min.

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) Hiram, Mo.

PARENTS
NAME OF FATHER Morris Barks
BIRTHPLACE OF FATHER Mo.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Julia Ann McCullough
BIRTHPLACE OF MOTHER Ark.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Ann Barks
(ADDRESS) Hiram, Mo.

Filed Aug 1, 1912 P. P. Burton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 31, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 26, 1912, to July 31, 1912,
that I last saw her alive on July 30, 1912,
and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:
Enterocolitis

Contributory
(SECONDARY) _____

(Signed) P. P. Burton M. D.
Aug. 1, 1912 (Address) Lowndes, 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 Nixon Cemetery DATE OF BURIAL Aug. 1, 1912

UNDERTAKER McLane & Kinder ADDRESS Lowndes, Mo.

Revised United States Standard Certificate of Death

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

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