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

PLACE OF DEATH

County Cass

Township ____ or Village West Line or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 160 File No. 29000

Primary Registration District No. 4094 Registered No. 7

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

FULL NAME Marilla Jane Boggs

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: October (Month) 31 (Day), 1839 (Year)

AGE: 72 yrs. 10 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): House-wife

BIRTHPLACE (City or town, State or foreign country): North Carolina

PARENTS

NAME OF FATHER: Jonathan Thompson

BIRTHPLACE OF FATHER (City or town, State or foreign country): not known

MAIDEN NAME OF MOTHER: ~~Maria~~ Mourah Erwin

BIRTHPLACE OF MOTHER (City or town, State or foreign country): not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Boggs

(ADDRESS) West Line Mo.

Filed 9-11-, 1912. Dr. W. A. Moore, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September (Month) 10 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 22, 1912, to Sept 10, 1912, that I last saw her alive on Sept 10, 1912, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
82.A
82D
64

(Duration) — yrs. — mos. 19 ds.

Contributory (SECONDARY) Hemiplegia

(Duration) — yrs. — mos. 19 ds.

(Signed) W A Moore M. D.

9-11-, 1912 (Address) West Line, 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: Glenwild Cemetery

DATE OF BURIAL: 9-12-1912

UNDERTAKER: L. Williams

ADDRESS: Louisburg Ks

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, peritonaeum*, 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 *septichaemia*," "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.)

HUGH STEPHENS, JEFFERSON CITY.

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

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

PLACE OF DEATH

County Cass

Township _____ or Village West Line or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 160 File No. 29000

Primary Registration District No. 4094 Registered No. 7

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

FULL NAME Marilla Jane Boggs

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: Oct. 31 (Month) (Day), 1839 (Year)

AGE: 72 yrs. 10 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ mins.

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

BIRTHPLACE (City or town, State or foreign country) North Carolina

PARENTS
NAME OF FATHER: Jonathan Thompson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known
MAIDEN NAME OF MOTHER: Maural Ervin
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Boggs

(ADDRESS) West Line, Mo.

Filed 9-11-1912 Dr W. A. Moore
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 10 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 22, 1912, to Sept. 10, 1912 that I last saw her alive on Sept. 10, 1912, and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage
Hemiplegia

(Duration) — yrs. — mos. 19 ds.

Contributory (SECONDARY) Cerebral Haemorrhage

(Duration) — yrs. — mos. 19 ds.

(Signed) W. A. Moore M. D.

9-11, 1912 (Address) West Line, 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: Glenwood Cemetery

DATE OF BURIAL: 9-12, 1912

UNDERTAKER: H. L. Williams

ADDRESS: Louisberg

SUPPLEMENTARY

SEP

Original file, date _____, 19__

All information called for must be written on this Supplementary Certificate

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, peritonaeum*, 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 *septichaemia*," "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 Cass

Township

or Village West Line

or City (NO. St.; Ward)

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

Registration District No. 160

Primary Registration District No. 4094

BUREAU OF ... CERTIFICATE OF DEATH

File No. 29,000

Registered No.

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

FULL NAME Marilla Jane Boggs

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: October (Month) 31 (Day), 1839 (Year)

AGE: 72 yrs. 10 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) House-wife

BIRTHPLACE (City or town, State or foreign country) North Carolina

PARENTS

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) A. M. Boggs

(ADDRESS) West Line, Mo.

Filed 9—11—1912 Dr. W. A. Moore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 10 (Month) (Day) 1912 (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:

(Cerebral Haemorrhage)

~~Hemiplegia~~

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

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

(Signed) Dr. W. A. Moore M. D.

9—11—1912 (Address) West Line, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

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Former or usual residence

PLACE OF BURIAL OR REMOVAL: Glenwild Cemetery

DATE OF BURIAL: 9—12—1912

UNDERTAKER: H. L. Williams

ADDRESS: Lansburg Ks

Original file, date 9—11—1912 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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