

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

PLACE OF DEATH *Armstrong*  
County *Green*  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City *Springfield* (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. *318* File No. *29328*  
Primary Registration District No. *2001* Registered No. *495*

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

FULL NAME *Jessie Rice*

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Female</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED <i>infant</i> <small>(Write the word)</small>
DATE OF BIRTH <i>May 17, 1912</i> <small>(Month) (Day) (Year)</small>		
AGE <i>4</i> yrs. <i>4</i> mos. <i>4</i> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <i>infant</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>0</i>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
*Sept 19, 1912*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Sept 19, 1912*, to *Sept 19, 1912*, that I last saw her alive on *Sept 19, 1912*, and that death occurred, on the date stated above, at *8 A.M.*

The CAUSE OF DEATH\* was as follows:  
*1180*  
*Acute Indigestion*  
*about 3 hrs*

Contributory (SECONDARY)  
*102*  
(Duration) yrs. mos. ds.  
(Signed) *Arthur Armstrong* M. D.  
*Mo 9-19, 1912* (Address) *Springfield 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 \_\_\_\_\_

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

PARENTS	NAME OF FATHER <i>George Rice</i>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Christian Co</i>
	MAIDEN NAME OF MOTHER <i>Bessie East</i>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Christian Co</i>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *George Rice*  
(ADDRESS) *738 W. Olive St.*

PLACE OF BURIAL OR REMOVAL  
*Deer Cemetery*  
DATE OF BURIAL  
*Sept 20, 1912*  
UNDERTAKER  
*W. C. Johnson*  
ADDRESS  
*305 W. Walnut*

Filed *Sept 19, 1912* *Wilbur Smith*  
REGISTRAR

# 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*, *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 *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

REGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty Greene

Township \_\_\_\_\_

or  
Village \_\_\_\_\_or  
City Springfield (NO. \_\_\_\_\_)Registration District No. 318Primary Registration District No. 2001File No. 29328Registered No. 495(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number)

FULL NAME

Jessie Rice

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

whiteSINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)infant

DATE OF BIRTH

May 17, 1912  
(Month) (Day) (Year)

AGE

4  
yrs. 4 mos. ds.IF LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ mins.

OCCUPATION

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

BIRTHPLACE

(City or town,  
State or foreign country)Springfield, Mo.NAME OF  
FATHERGeorge RiceBIRTHPLACE  
OF FATHER

(City or town, State or foreign country)

Christian Co.MAIDEN NAME  
OF MOTHERBessie EastBIRTHPLACE  
OF MOTHER

(City or town, State or foreign country)

Christian Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Rice

(ADDRESS)

738 W. Olive St.

Filed

Sept 14, 1912 Walter Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Sept. 19, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Sept. 19, 1912, to Sept. 19, 1912that I last saw her alive on Sept. 19, 1912,and that death occurred, on the date stated above, at 80 a.m.

The CAUSE OF DEATH\* was as follows:

acute indigestion(Duration) about 3 hrs.

Contributory

(SECONDARY)

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

(Signed) Arthur Armstrong M. D.9-19, 1912 (Address) Springfield, 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

Lee Cemetery

DATE OF BURIAL

Sept. 20, 1912

UNDERTAKER

W.C. Lohmeyer

ADDRESS

300 W. Walnut

Original file, date

SEP

, 19 \_\_\_\_\_

All information called for must be written in 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 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.)

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

N. B.—Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Green  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CERTIFICATE OF DEATH

Registration District No. \_\_\_\_\_ File No. 29238  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

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

FULL NAME

Jessie Rice

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, _____, 191____ (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. _____ 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) _____		
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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_, 191\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Indigestion of (liver here)  
Gastric Intestinal Intoxication

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

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

(Signed) Dr. Arthur Armstrong M. D.  
\_\_\_\_\_ 191\_\_\_\_ (Address)

SUPPLEMENTARY

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
Filed \_\_\_\_\_ 191\_\_\_\_  
REGISTRAR

\*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 _____

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