

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.

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

PLACE OF DEATH
County Harrison
Township Hamilton
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 937 File No. 29375
Primary Registration District No. 32173 Registered No. 16

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

FULL NAME Eveline Leah

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH November 17, 1930
(Month) (Day) (Year)

AGE 81 yrs. 10 mos. 11 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) 9-0

BIRTHPLACE (City or town, State or foreign country) Coopersstown Town Pennsylvania

PARENTS
NAME OF FATHER Jacob Leish
BIRTHPLACE OF FATHER (City or town, State or foreign country) not known
MAIDEN NAME OF MOTHER Ann Benson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pennsylvania

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Leah
(ADDRESS) Englewood Mo.

Filed Sept. 28, 1912 B.S.R. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 23, 1912, to Sept 26, 1912, that I last saw her alive on Sept 26, 1912, and that death occurred, on the date stated above, at 6 p. am.
The CAUSE OF DEATH* was as follows:

Pneumonia
10979

Contributory (SECONDARY) (Duration) yrs. mos. ds. 7 ds.
(Signed) W. Roberts M. D.
Sept 28, 1912 (Address) Englewood 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 Englewood Cemetery DATE OF BURIAL Sept 29, 1912
UNDERTAKER Chas E. Anderson ADDRESS Englewood 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, 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," "Anacmia" (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 RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

County Harrison
 Township Hamilton
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 337 File No. 29375
 Primary Registration District No. 5473 Registered No. 16

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

FULL NAME Eveline Lesh

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Sept. 28, 1912
 (Month) (Day) (Year)

DATE OF BIRTH Nov. 17, 1830
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 23, 1912, to Sept. 26, 1912, that I last saw her alive on Sept. 26, 1912, and that death occurred, on the date stated above, at 6 p. m.

AGE 81 yrs. 10 mos. 11 ds. IF LESS than 1 day, ___ hrs. or ___ min.

The CAUSE OF DEATH* was as follows:
Branch Pneumonia
 (Duration) _____ yrs. _____ mos. 7 ds.

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) Cooperstown Pa.

PARENTS NAME OF FATHER Jacob Reist
 BIRTHPLACE OF FATHER (City or town, State or foreign country) North Harrison Pa.
 MAIDEN NAME OF MOTHER Agnes Penn
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. H. Anderson M. D.
Sept. 28, 1912 (Address) Eagleville Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Alice Lesh
 (ADDRESS) Eagleville, 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 _____

Filed Sept 20, 1912 by J. J. Downing REGISTRAR

PLACE OF BURIAL OR REMOVAL Eagleville Cemetery DATE OF BURIAL Sept. 29, 1912
 UNDERTAKER Chas. E. Anderson ADDRESS Eagleville

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 "Asthemia," "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.)