

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.

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

PLACE OF DEATH  
County Stone  
Township Lincoln  
or  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 1044 File No. 31735  
Primary Registration District No. 6259 Registered No. \_\_\_\_\_

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

FULL NAME Leona McPanic

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Sept 28</u> , 191 <u>2</u> (Month) (Day) (Year)		
AGE <u>5</u> yrs. <u>4</u> mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE  
(City or town, State or foreign country) mo

PARENTS	NAME OF FATHER <u>J. H. McPanic</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>ark</u>
	MAIDEN NAME OF MOTHER <u>Seiber</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. H. McPanic  
(ADDRESS) Croft Mo

Filed Sept 28, 1912, A. Maceland  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH  
Sept 27, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 21, 1912, to Sept 27, 1912, that I last saw him alive on Sept 26, 1912, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH\* was as follows:  
Death was caused by typhoid fever

(Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 0  
Contributory Typhoid fever  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. H. McPanic M. D.  
Sept 27, 1912 (Address) Croft 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 usual residence

PLACE OF BURIAL OR REMOVAL <u>Croft mo</u>	DATE OF BURIAL <u>Sept 27</u> , 191 <u>2</u>
UNDERTAKER <u>Bill Brown</u>	ADDRESS <u>Croft</u>

# 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"); *Elder 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.)



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

PLACE OF DEATH  
County Stone  
Township Lincoln  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 1044 File No. 31715 ✓  
Primary Registration District No. 6259 Registered No. 6

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

FULL NAME Leona McDanies

## PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE 5 yrs. 4 mos.  ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

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

PARENTS  
NAME OF FATHER J. H. McFarrell  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark.  
MAIDEN NAME OF MOTHER Mary Seiber  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. H. McDanies  
(ADDRESS) Croce, Mo.

Filed Nov 25 1912 A. S. S. S. S. S. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 27, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 21, 1912, to Sept. 27, 1912, that I last saw her alive on Sept. 26, 1912, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:  
Death was caused by typhoid fever

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

(Signed) J. H. McFarrell M. D.  
Sept. 27 1912 (Address) Croce, 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 Croce, Mo. DATE OF BURIAL Sept. 27 1912

UNDERTAKER Bill Brown ADDRESS Croce, Mo.

Original file. date SEP 28 1912 All information called for must be written on this Supplementary Certificate.

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

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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 "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.)