

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 Dunklin  
Township 2<sup>nd</sup> City  
Village ~~Harpersville~~  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 287 File No. 3254U  
Primary Registration District No. 5406 Registered No. 58

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

FULL NAME Walter Carter

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Female</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)	
DATE OF BIRTH <u>Dec. 17, 1892</u> (Month) (Day) (Year)		If LESS than 1 day, ___ hrs. or ___ min.?	
AGE <u>18 yrs. 9 mos. 13 ds.</u>			
OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-30</u>			
BIRTHPLACE (City or town, State or foreign country) <u>Quincy Miss</u> <u>Ire Calif</u>			
PARENTS	NAME OF FATHER <u>W. H. Carter</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Miss</u>		
	MAIDEN NAME OF MOTHER <u>Sida King</u>		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Quincy Miss</u>		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Oct. 17, 1912</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Oct 2</u> , 1912, to <u>Oct 13</u> , 1912, that I last saw <u>her</u> alive on <u>Oct 13</u> , 1912, and that death occurred, on the date stated above, at <u>109</u> m.	
The CAUSE OF DEATH* was as follows: <u>Tuberculosis</u> <u>33A</u>	
(Duration) ___ yrs. ___ mos. ___ ds.	
Contributory (SECONDARY) <u>John H. Lambaugh</u> (Duration) ___ yrs. ___ mos. ___ ds. (Signed) <u>John H. Lambaugh</u> M. D. <u>Oct 17, 1912</u> (Address) <u>Harpersville</u>	
*State the Disease Cause, Path, 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 <u>Harpersville Mo.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) W a Carter, Harpersville  
Filed Oct. 17, 1912 John H. Lambaugh  
REGISTRAR

PLACE OF BURIAL OR REMOVAL  
Harpersville Mo

DATE OF BURIAL  
Oct. 18, 1912

UNDERTAKER  
W. S. Lambaugh

ADDRESS  
Harpersville

# 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*, *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 septicæmia," "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.)



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MISSOURI STATE BOARD OF HEALTH

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

PLACE OF DEATH  
 County Hicklin  
 Township Clay  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 287 File No. 32541  
 Primary Registration District No. 0400- Registered No. 08

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

FULL NAME Certa Carter

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(If write the word)

DATE OF BIRTH Dec. 17, 1894  
(Month) (Day) (Year)

AGE 18 yrs. 9 mos. 13 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE  
 (City or town; State or foreign country) Miss. Emmet

PARENTS  
 NAME OF FATHER W. A. Carter  
 BIRTHPLACE OF FATHER Miss.  
 (City or town, State or foreign country)  
 MAIDEN NAME OF MOTHER Eda Long  
 BIRTHPLACE OF MOTHER Miss.  
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) W. A. Carter  
 (ADDRESS) Harrisonville

Filed Dec. 12 1912 Ed. L. Lamb  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 17, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 13, 1912, to Oct. 13, 1912, that I last saw her alive on Oct. 13, 1912, and that death occurred, on the date stated above, at 100 a.m.

The CAUSE OF DEATH\* was as follows:  
Tuberculosis of the Lungs  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 (SECONDARY) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Ed. L. Lamb M. D.  
Oct. 17, 1912 (Address) Harrisonville

\*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 Harrisonville Mo DATE OF BURIAL Oct. 18, 1912  
 UNDERTAKER J. F. Kinsding ADDRESS Halle

Original file, date OCT 17, 1912 All information called for must be written on this Supplementary Certificate.

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