

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.

PLACE OF DEATH

County Jasper

Township _____

or _____

Village _____

or _____

City CarthageRegistration District No. 408File No. 33155Primary Registration District No. 3020Registered No. 740(NO. 724 E. Fifth St.; _____ Ward)

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

FULL NAME Arama Lillian Adams

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 5, 1912
(Month) (Day) (Year)

AGE 2 yrs. 29 mos. 29 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 Carthage, Missouri
(City or town, State or foreign country)

NAME OF FATHER Raymond Adams

BIRTHPLACE OF FATHER Carthage, Missouri
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Iva Roberts

BIRTHPLACE OF MOTHER Carthage, Missouri
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Raymond Adams(ADDRESS) Carthage, Mo.Filed Oct 2, 1912 James B. Lord

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 2, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 2, 1912, to Oct 2, 1912, that I last saw her alive on Oct 2, 1912, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Convulsions
3 1/2 hrs. 0 mos. 6 hrs. ds.
(Duration) (yrs.) (mos.) (ds.)

Contributory (SECONDARY) _____

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

(Signed) J. B. Thomas M. D.

Oct 2, 1912 (Address) Carthage, 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 Carthage, Missouri

PLACE OF BURIAL OR REMOVAL Edgar Hill Cemetery

DATE OF BURIAL Oct 4, 1912

UNDERTAKER Knell Munk Co.

ADDRESS Carthage, 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, 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.)

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.

PLACE OF DEATH Jasper

County Jasper

Township Carthage or Village Carthage or City Carthage (NO. 724 E. Fifth St.; 140 Ward)

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 408 File No. 140

Primary Registration District No. 3020 Registered No. 140

FULL NAME Arama Lillian Adams

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>Oct. 2</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>July 5</u> , 191 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Oct. 2</u> , 191 <u>2</u> , to <u>Oct. 2</u> , 191 <u>2</u> , that I last saw her alive on <u>Oct. 2</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>X</u> m.	
AGE <u>2</u> yrs. <u>29</u> mos. <u>29</u> ds.			The CAUSE OF DEATH* was as follows: <u>Convulsions</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)			<u>Malaria</u> <u>X</u> (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Carthage, Mo.</u>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Raymond Adams</u>		(Signed) <u>E. B. Thomas</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Carthage</u>		<u>Oct. 2</u> , 191 <u>2</u> (Address) <u>Carthage, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Lily Roberts</u>		*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Carthage</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Raymond Adams</u> (ADDRESS) <u>Carthage, Mo.</u>				
Filed <u>June 6</u> 191 <u>2</u> <u>38</u> <u>James B. Lloyd</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Cedar Hill Cem.</u>	
			DATE OF BURIAL <u>Oct. 7</u> , 191 <u>2</u>	
			UNDERTAKER <u>Knell Undert. Co.</u>	
			ADDRESS <u>Carthage, Mo.</u>	

Original file. date. 2, 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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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*" ("*Con-*
genital," "*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.)

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