

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 Gasper
Township _____
or
Village _____
or Webb City (NO. E 2nd St. St.; _____ Ward)

Registration District No. 417 File No. 33244
Primary Registration District No. 3021 Registered No. 177

FULL NAME Barah C. Huddleston

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

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE child MARRIED child WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH May 20, 1912
(Month) (Day) (Year)
AGE 5 yrs. 2 mos. 2 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) 0

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

PARENTS: NAME OF FATHER Noah Huddleston BIRTHPLACE OF FATHER (City or town, State or foreign country) Jill MAIDEN NAME OF MOTHER Victoria Cannon BIRTHPLACE OF MOTHER (City or town, State or foreign country) Miss

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Victoria Huddleston (ADDRESS) Webb City Mo

Filed Oct 23, 1912 E. H. Baird REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 22, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 13, 1912, to Oct 22, 1912, that I last saw her alive on Oct 19, 1912, and that death occurred, on the date stated above, at 11:30 am.

The CAUSE OF DEATH* was as follows: Inevitiam
151

Contributory (SECONDARY) Mal-nutritiam
(Duration) yrs. 5 mos. ds.

(Signed) A. N. Winchester M. D. (Address) Joplin Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state the 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 Cartersville Cem DATE OF BURIAL Oct. 23, 1912
UNDERTAKER Webb City Bur. Co ADDRESS Webb City 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, peritoneum*, 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 carbonic 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.

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PLACE OF DEATH

County Jasper
Township _____
or
Village _____
or
City Webb City (NO. E. 2nd St. St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No. 417 File No. 33244
Primary Registration District No. 3021 Registered No. 177
FULL NAME Barah C. Huddleston
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Child</u>
DATE OF BIRTH <u>May 20</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE <u>5</u> yrs. <u>2</u> mos. <u>2</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Webb City, Mo.</u>		
PARENTS	NAME OF FATHER <u>Noah Huddleston</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>	
	MAIDEN NAME OF MOTHER <u>Victoria Cannon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Miss.</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>Oct. 22</u> , 19 <u>12</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>Aug 13</u> , 19 <u>12</u> , to <u>Oct. 22</u> , 19 <u>12</u> , that I last saw her alive on <u>Oct. 19</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at <u>11:30 a. m.</u>
The CAUSE OF DEATH* was as follows: <u>Inanition</u> <u>Marasmus</u>
(Duration) ___ yrs. ___ mos. ___ ds.
Contributory <u>Malnutrition</u> (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) <u>A. S. Winchester</u> M. D. <u>Oct. 22</u> 19 <u>12</u> (Address) <u>Joplin, Mo.</u>
*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Victoria Huddleston
(ADDRESS) Webb City, Mo.
Filed Oct 23 # 224 H. Baird & _____
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Cartersville Cem,
DATE OF BURIAL
Oct. 20 1912
UNDERTAKER
Webb City, Ind. Co.
ADDRESS
Webb City,

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.)

PLACE OF BIRTH

County

Joseph

Township

or

Village

or

City

Webb City

(NO.

E. 2nd St

St.

Ward)

FULL NAME

Sarah C. Huddleston

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

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

Registration District No.

4-17

File No.

33244

Primary Registration District No.

3021

Registered No.

177

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

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (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) _____

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ Oct 22, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Incontinence
macosurus
Improper food & lack of hygiene
(Duration) _____ yrs. _____ mos. _____ ds.Contributory Mal-nutrition
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. N. Hinchman M. D. Apr 3 - 1913 (Address) Joseph Mo

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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 _____

SUPPLEMENTARY

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D. M. Wheeler - 620 Main St - Joseph Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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