

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		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<i>Sullivan</i>	Registration District No.	<i>850</i>
Township	<i>Liberty</i>	File No.	<i>35075</i>
or		Primary Registration District No.	<i>6117</i>
Village	<i>Harris</i>	Registered No.	<i>10</i>
or			
City	<i>R.R.</i> (NO. _____) St. _____ Ward _____		
FULL NAME		<i>Hannah Bell Sanders</i>	
[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	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Oct 11</i> , 191 <i>2</i>
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from _____, 191 <i>1</i> , to _____, 191 <i>2</i> ,
<i>Mar 8</i> , 1855 (Month) (Day) (Year)			that I last saw h. _____ alive on _____, 191 <i>1</i> ,
AGE	If LESS than 1 day, _____ hrs. or _____ min.?		and that death occurred, on the date stated above, at <i>11<sup>34</sup></i> pm.
<i>57</i> yrs. <i>7</i> mos. <i>2</i> ds.			The CAUSE OF DEATH* was as follows:
OCCUPATION (a) Trade, profession, or particular kind of work	<i>House Widow</i>		<i>Heart Failure</i>
(b) General nature of industry, business, or establishment in which employed (or employer)	<i>Harris</i>		<i>930</i>
BIRTHPLACE (City or town, State or foreign country)	<i>Indiana</i>		(Duration) _____ yrs. _____ mos. _____ ds.
PARENTS	NAME OF FATHER	<i>Mr. Butsinger</i>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	<i>Ky</i>	
	MAIDEN NAME OF MOTHER	<i>Elizabeth Butsinger</i>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<i>Ky</i>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant)	<i>Flويد Sanders</i>		
(ADDRESS)	<i>Harris, Missouri</i>		
Filed	<i>Oct 12</i> , 191 <i>2</i>	<i>C. F. Shriver</i>	REGISTRAR
PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL	
<i>Union Grove</i>		<i>Oct 12</i> , 191 <i>2</i>	
UNDERTAKER		ADDRESS	
<i>Carpenter Bros</i>		<i>Osgood</i>	

# 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 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.)



ORIGINAL; WITH UNFADING INK—THIS IS A SUPPLEMENTARY CERTIFICATE.

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PLACE OF DEATH

County Sullivan  
Township Liberty  
or  
Village  
or  
City (NO. \_\_\_\_\_ 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. 850 File No. 35075  
Primary Registration District No. 6117 Registered No. 10

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

FULL NAME Nannah Bell Sanders.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (# write the word) <u>W.</u>
DATE OF BIRTH <u>Mar. 8</u> , 1 <u>855</u> (Month) (Day) (Year)		
AGE <u>57</u> yrs. <u>7</u> mos. <u>2</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Widow</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>Wm. G. Leutsinger</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Sky.</u>	
	MAIDEN NAME OF MOTHER <u>Eliza Leutsinger</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Sky.</u>	

RECEIVED SEP 21 1912

MEDICAL CERTIFICATE OF DEATH  
DATE OF DEATH  
Oct. 11, 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 11 3/4 p.m.

The CAUSE OF DEATH\* was as follows:  
Heart Failure  
Degeneration of the Heart

Contributory (SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) C. F. Shriver M. D.  
Oct 11, 1912; (Address) Harris 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Flois Sanders  
(ADDRESS) Harris, Mo.

PLACE OF BURIAL OR REMOVAL  
Union Grove  
DATE OF BURIAL  
Oct. 12, 1912  
UNDERTAKER  
Carpenter Bros.  
ADDRESS  
Osgood.

Filed Oct 12, 1912, C. F. Shriver REGISTRAR

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Association]

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