

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

PLACE OF DEATH
County Adair
Township Morrow
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1039 File No. 35218
Primary Registration District No. 5010 Registered No. 5

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

FULL NAME Martha Bouffer

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH Not known
(Month) (Day) (Year)

AGE 46 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) 9-0

BIRTHPLACE
(City or town, State or foreign country) Adair Co Mo

NAME OF FATHER Samuel Wiles

BIRTHPLACE OF FATHER
(City or town, State or foreign country) not known

MAIDEN NAME OF MOTHER Eytherson

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Adair Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G F VanBingham

(ADDRESS) Greencastle mo

Filed Nov 20 1912 James S. Reep
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 13, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1912, to _____, 1912, that I last saw her alive on Aug 10, 1912, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis 23A
trauma 18 1912

Unknown (Duration) ____ yrs. ____ mos. ____ ds.

Contributory traumatic injury to left lung (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Wm Parsons M. D.
Nov 13, 1912 (Address) Greencastle 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 Greencastle mo DATE OF BURIAL 11/14, 1912

UNDERTAKER W H Council ADDRESS Greencastle mo

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.

WHILE I LIVE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Adair
Township Morrow
or
Village _____
or
City _____ (NO. _____)

Registration District No. 1039 File No. 5
Primary Registration District No. 2010 Registered No. 15
St. _____ Ward _____

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

FULL NAME Martha Bouffer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED married
OR WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Not known
(Month) (Day) (Year)
AGE 46 yrs. mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Nov. 13, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Aug. 1, 1912, to _____, 1912,
that I last saw her alive on Aug. 10, 1912,
and that death occurred, on the date stated above, at 6 p. m.
The CAUSE OF DEATH* was as follows:

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

Tuberculosis
Injury from being hit with ribs by a mans fist on his right arm (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Traumatic injury to left lung (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Crump M. D.
Nov. 13, 1912 (Address) Greencastle Mo.

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

PARENTS
NAME OF FATHER Samuel Wiles
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Adair Co. 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) W. Vanling
(ADDRESS) Greencastle Mo.

PLACE OF BURIAL OR REMOVAL Greencastle Mo. DATE OF BURIAL 11-14 1912
UNDERTAKER W. H. Crump ADDRESS Greencastle

Filed Jan 10, 1913, James S. Reid REGISTRAR

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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; Spuck 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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