

WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Jackson
Township Smobar
or
Village Blue Springs
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 375 File No. 39159
Primary Registration District No. 555/4 Registered No. 74

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

FULL NAME Martha P. Parr

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 10, 1834
(Month) (Day) (Year)

AGE 78 yrs. 9 mos. 18 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Kentucky

NAME OF FATHER John Smith

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

MAIDEN NAME OF MOTHER Rebecca Maxwell

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Parr

(ADDRESS) Blue Springs, Mo.

Filed Dec 14, 1912 E. S. Starns
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct - 15, 1912 to Nov 28, 1912 that I last saw h. alive on Nov 26, 1912 and that death occurred, on the date stated above, at 9:30 m. The CAUSE OF DEATH* was as follows:

Chronic Debility
15 yr (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. Smith M. D.
Nov 28, 1912 (Address) Blue Springs, 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 Blue Springs DATE OF BURIAL 11-29-1912

UNDERTAKER John W. Stanley ADDRESS Blue Springs 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*, *Composer*, *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.)



REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHPLACE OF DEATH
County Jackson
Township Linbar
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)Registration District No. 395 File No. _____
Primary Registration District No. 5551A Registered No. 74
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Martha P. Parr

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m.</u>
DATE OF BIRTH <u>March 10</u> , 18 <u>34</u> (Month) (Day) (Year)		
AGE <u>78</u> yrs. <u>9</u> mos. <u>18</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u>		
(b) General nature of Industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		
PARENTS	NAME OF FATHER <u>Wm. Smith</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	
	MAIDEN NAME OF MOTHER <u>Rebega Maxwell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH <u>Nov. 28</u> , 191 <u>2</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>Oct 15</u> , 191 <u>2</u> , to <u>Nov. 28</u> , 191 <u>2</u> , that I last saw h <u>er</u> alive on <u>Nov-26</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>9:30 a</u> m.
The CAUSE OF DEATH* was as follows: <u>Spec. Debility</u> <u>She had a fall out of</u> <u>Coast road house on</u> <u>Cap Hill</u> (Duration) ___ yrs. ___ mos. ___ ds.
Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) <u>J. Smith</u> M. D. <u>Nov. 28</u> , 191 <u>2</u> (Address) <u>Blue Springs, 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) John H. Parr
(ADDRESS) Blue Springs Mo
Filed Dec. 14, 1912 E. S. Garrison
REGISTRARPLACE OF BURIAL OR REMOVAL
Blue Springs
DATE OF BURIAL
11-29, 1912
UNDERTAKER
John W. Stanley
ADDRESS
Blue Springs Mo.Original file date Dec 14, 1912 All information called for must be written on this Supplementary Certificate.

WRITE PLAINLY, WITH A UNIFORM INK—THIS IS A PERMANENT RECORD

If any information should be carefully supplied, AGE should be stated in PLAIN TERMS, so that it may be properly classified. Exact state of DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION in very important.

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" ("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.)

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