

WRITE PLAINLY IN 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 Laclede

Township Union

or Village _____

or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 448

File No. 39700

Primary Registration District No. 5608

Registered No. _____

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

FULL NAME Carrie A. McMenus

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 27, 1912
(Month) (Day) (Year)

AGE 34 yrs. 2 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Eli McMenus
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
MAIDEN NAME OF MOTHER Emily A. Martin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) West Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Davis

(ADDRESS) County Mo

Filed Dec 10, 1912 W R Summers

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Nov 6, 1912, to Nov 28, 1912, that I last saw her alive on Nov 28, 1912, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Septicemia following
an Abortion

140 (Duration) ___ yrs. ___ mos. 20 ds.

Contributory (Secondary) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W R Summers M. D.
Nov 29, 1912 (Address) County 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 Twilight Cemetery DATE OF BURIAL Nov 30, 1912

UNDERTAKEN _____ ADDRESS _____

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

County _____
 Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 or City _____ (NO. _____) St. _____ Ward _____
 ([If death occurred in a hospital or institution, give its NAME instead of street and number])

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____
 If LESS than 1 day, _____ hrs. _____ min.?
 or _____ yrs. _____ mos. _____ ds.

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 _____ (Month) _____, 191____ (Day) _____, 191____ (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:

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____, 191____ (Address) _____

*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. 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, WITH UNFADING INK, FOR 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.

PLACE OF DEATH

County Laclede
 Township Union
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

CERTIFICATE OF DEATH
 Registration District No. 448 File No. 39700
 Primary Registration District No. 5608 Registered No. _____

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

FULL NAME Leanne A. McMenus.

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S.
(if fill the word)

DATE OF BIRTH Sept. 27, 1878
(Month) (Day) (Year)

AGE 34 yrs. 2 mos. 1 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Lived at home
 (b) General nature of industry, business, or establishment in which employed (or employer) housework

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

PARENTS
 NAME OF FATHER Eli McMenus
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
 MAIDEN NAME OF MOTHER Emily A. Martin
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) New Hampshire

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ida Davis
 (ADDRESS) Conway Mo.

Filed Dec. 10 1912 W. P. Summers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 26, 1912, to Nov. 28, 1912, that I last saw her alive on _____, 1912, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Septicemia following an abortion
 (Duration) _____ yrs. _____ mos. 20 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. P. Summers M. D.
Nov. 29, 1912 (Address) Conway 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 Twilight Cem DATE OF BURIAL Nov. 30, 1912
 UNDERTAKER W. C. Newport Conway Mo. ADDRESS _____

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^v 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 for 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.)