

## PLACE OF DEATH

County StoneTownship Flat Creekor  
Village ✓or  
City ✓Registration District No. 1096Primary Registration District No. 6247File No. 41754Registered No. 9

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

FULL NAME Sarah E. Stone

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>
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DATE OF BIRTH March 26, 1826  
(Month) (Day) (Year)AGE 86 yrs. 8 mos. 21 ds.  
If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?OCCUPATION  
(a) Trade, profession, or particular kind of work housekeeper  
Nothing formerly  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓BIRTHPLACE  
(City or town, State or foreign country) KentuckyNAME OF FATHER John B. WilliamsBIRTHPLACE OF FATHER  
(City or town, State or foreign country) Not knownMAIDEN NAME OF MOTHER Alice LewisBIRTHPLACE OF MOTHER  
(City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. P. Stone  
(ADDRESS) Cape Fair Mo.Filed 12/18 1912 by Chas. H. Barney

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 17<sup>th</sup>, 1912  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec. 10<sup>th</sup>, 1912, to Dec. 13, 1912, that I last saw h.c.y alive on Dec. 13, 1912, and that death occurred, on the date stated above, at 7:45 P.m.

The CAUSE OF DEATH\* was as follows:

Senility  
Fracture of femur  
(Duration) ✓ yrs. ✓ mos. ✓ ds.Contributory Fracture of femur  
(SECONDARY) (Duration) no yrs. no mos. 7 ds.(Signed) L. Benson M. D.  
12/18, 1912 (Address) Galena 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? Place of death

Former or usual residence

PLACE OF BURIAL OR REMOVAL Cape Fair Mo. DATE OF BURIAL Dec. 19, 1912UNDERTAKER Dennis Ward ADDRESS Cape Fair Mo.

## PLACE OF DEATH

County \_\_\_\_\_  
 or  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_

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

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 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 rite the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	(Month) _____ (Day) _____ (Year) _____	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

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_, 191\_\_\_\_

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:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory

(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*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

UNDERTAKER

ADDRESS

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

PLACE OF DEATH

County Stone  
 Township Flat Creek  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 1096 File No. \_\_\_\_\_  
 Primary Registration District No. 6247 Registered No. 9

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

FULL NAME Sarah E. Stone

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widow  
 (#rite the word)

DATE OF BIRTH March 26, 1826  
 (Month) (Day) (Year)

AGE 86 yrs. 8 mos. 21 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

PARENTS  
 NAME OF FATHER John B. Williams  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known  
 MAIDEN NAME OF MOTHER Allice Lewis  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) Geo. L. Stone

(ADDRESS) Cape Fair, Mo.  
 Filled 12/18/12 1912  
 REGISTRAR Chas. H. Best

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 17, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 10, 1912, to Dec. 13, 1912, that I last saw her alive on Dec. 13, 1912, and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH\* was as follows:  
Senility  
and accidental fracture of the femur

Contributory accidental fracture of the femur  
 (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) L. Deenoy M. D.  
12/18, 1912 (Address) Galena, 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 Cape Fair Mo. DATE OF BURIAL Dec. 19, 1912

UNDERTAKER Dennis Ward ADDRESS Cape Fair 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. 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.

# 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 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.)

41754

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.

PLACE OF DEATH

County Stou

Township \_\_\_\_\_

or Village \_\_\_\_\_

or City \_\_\_\_\_

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. \_\_\_\_\_

File No. 41754

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

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

FULL NAME

Sarah E. Stoue

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) \_\_\_\_\_

PARENTS 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 Dec. 17, 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: Fracture of Femur. She was walking across the floor and fell. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_ (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) L. Henson M. D. 191\_\_\_\_ (Address) Galena 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# 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.)