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

PLACE OF DEATH

County Adair

Township Salt River

or

Village

or

City (NO. , St.; Ward)

Registration District No. One

Primary Registration District No. 5001

File No. 2

Registered No. 1

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

FULL NAME Amanda Martin

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: Aug (Month) 30 (Day), 1849 (Year)

AGE: 63 yrs. 4 mos. 3 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Ind.

PARENTS

NAME OF FATHER: Isgreg

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

MAIDEN NAME OF MOTHER: Nancy Wells

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas C Martin

(ADDRESS) Gibbs Mo.

Filed Jan 3, 1913 F M Barnes REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 3 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 19th, 1912, to January 3, 1913, that I last saw her alive on January 3, 1913, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cysto Fibroma of Ovary

139A

129 (Duration) Indefinite mos. ds.

Contributory (SECONDARY) Peritonitis

(Duration) yrs. mos. 6 ds.

(Signed) F M Barnes M. D.

Jan 3, 1913 (Address) Brashear 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: New Cemetery

DATE OF BURIAL: 1/5" 1913

UNDERTAKER: F. R. Easley

ADDRESS: Brashear Mo.

[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," "Exhaus failure," "Haemorrhage," "Inanition," "Mal age," "Shock," "Uraemia," "Weakness," definite disease can be ascertained as the c qualify all diseases resulting from child carriage, as "PUERPERAL *septichaemia*," *peritonitis*," etc. State cause for which sur was undertaken. For VIOLENT DEATHS s INJURY and qualify as ACCIDENTAL, SUICI CIDAL, or as *probably* such, if impossible definitely. Examples: *Accidental drown railway train—accident; Revolver wound of h Poisoned by carbolic acid—probably suicide.* 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.)

MARGIN RESERVED

WRITE ... IN—THIS IS A PERMANENT RECORD

N. B.—Every item of information ... be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in ... statement of ... important.

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

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

PLACE OF DEATH

County: Adair

Township: Salt River

or

Village:

or

City: (NO. St.: Ward)

Registration District No.: 1

File No.:

Primary Registration District No.: 5001

Registered No.: 1

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

FULL NAME Amanda Martin

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: Aug. 30, 1849 (Month) (Day) (Year)

AGE: 63 yrs. 4 mos. 3 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): Ind.

PARENTS

NAME OF FATHER: informant dident know first name Isaug

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ind.

MAIDEN NAME OF MOTHER: Nancy Wells

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles C Martin X

(ADDRESS) Gibbs, Mo.

Filed March 7, 1913 F M Barnes X REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. 3, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 19, 1912, to Jan. 3, 1913, that I last saw her alive on Jan. 3, 1913, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Cysto Fibroma of Left ovary

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

Contributory (SECONDARY) Peritonitis

(Duration) ___ yrs. ___ mos. 6 ds.

(Signed) F. M. Barnes M. D.

Jan. 3, 1913 (Address) Brashear, 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: Mo. Cemetery

DATE OF BURIAL: 1/5 1913

UNDERTAKER: F. R. Easley

ADDRESS: Brashear Mo.

Original file, date JAN 3, 1913 All information called for must be written on this Supplementary Certificate

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 *septichaemia*," "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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