

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 Buchanan  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City St. Joseph (NO. St. Josephs Hospital)

Registration District No. 85 File No. 232  
Primary Registration District No. 1007 Registered No. 98  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Nancy Alexander

PERSONAL AND STATISTICAL PARTICULARS

|                                                                                                                                                                                         |                                                                              |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------|
| SEX<br><u>Female</u>                                                                                                                                                                    | COLOR OR RACE<br><u>White</u>                                                | MARRIED<br><u>married</u><br>(If wife the word) |
| DATE OF BIRTH<br><u>Sept 28, 1868</u><br>(Month) (Day) (Year)                                                                                                                           |                                                                              |                                                 |
| AGE<br><u>44</u> yrs. <u>3</u> mos. <u>23</u> ds.<br>IF LESS than 1 day, ____ hrs. or ____ min.?                                                                                        |                                                                              |                                                 |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Housewife</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> |                                                                              |                                                 |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Indiana</u>                                                                                                                   |                                                                              |                                                 |
| PARENTS                                                                                                                                                                                 | NAME OF FATHER <u>Unknown</u>                                                |                                                 |
|                                                                                                                                                                                         | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u> |                                                 |
|                                                                                                                                                                                         | MAIDEN NAME OF MOTHER <u>Unknown</u>                                         |                                                 |
|                                                                                                                                                                                         | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u> |                                                 |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Alexander  
(ADDRESS) 404 Angeliene St

Filed Jan 22 1913 W E Harrington  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 21, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15, 1913, to Jan 21st, 1913, that I last saw her alive on Jan 21st, 1913, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH\* was as follows:  
134 Acute Reluctation of Stomach  
118 Following operation for  
Repetitive hemorrhage  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

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

(Signed) Geo. M. Batley M. D.  
Jan 22, 1913 (Address) St. Joseph 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. 6 ds. In the 30 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted If not at place of death? 404 Angeliene St  
Former or usual residence 404 Angeliene St

PLACE OF BURIAL OR REMOVAL Maryville Mo  
DATE OF BURIAL Jan 23, 1913  
UNDERTAKER H. O. Bidwell  
ADDRESS 211-15th St

# Revised <sup>1917</sup> 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.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. YOUNG PERSONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not state age of child.

PLACE OF DEATH

County Buchanan

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City St. Joseph (NO. St. Joseph Hospital)

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Registration District No. 83 File No. \_\_\_\_\_  
Primary Registration District No. 1001 Registered No. 98  
St. \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Nancy Alexander

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept 28, 1868  
(Month) (Day) (Year)

AGE 44 3 23 yrs. mos. 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) Indiana

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) Samuel Alexander  
(ADDRESS) 404 Angelique Str.

Filed Feb 10, 1913 W. E. Harrington  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 21, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 13, 1913, to Jan. 21, 1913, that I last saw her alive on Jan. 21, 1913, and that death occurred, on the date stated above, at 64 m.  
The CAUSE OF DEATH\* was as follows:

Acute dilatation of stomach following operation for removing womb

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

(Signed) Geo. M. Bottler M. D.  
Jan. 22, 1913 (Address) St. Joseph, 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 Maryville Mo. DATE OF BURIAL Jan. 23, 1913

UNDERTAKER H. O. Sidenfaden ADDRESS 211-15 N 10th

# 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.)