

N. E. of info. furnished. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. Properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH Cass ✓
 County Cass Registration District No. 15-2 File No. 548
 Township Camp Branch or Village _____ Primary Registration District No. 5216 Registered No. 4
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Delina Close

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>Jan 27 1830</u> (Month) (Day) (Year)		
AGE <u>82</u> yrs. <u>11</u> mos. <u>28</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-10</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>Wm. Gilliam</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	MAIDEN NAME OF MOTHER <u>Anna Burkett</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>North Carolina</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 24 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1st, 1913, to Jan 24, 1913, that I last saw her alive on Jan 24, 1913, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:
Pneumonitis
109 A
97
 (Duration) ___ yrs. ___ mos. 8 ds.

Contributory (SECONDARY) Arteriosclerosis
Don't know
 (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. D. Ramsey M. D.
1-25- 1913 (Address) Carder City Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Is B. Chadd
 (ADDRESS) Carder City Mo

Filed 11-25- 1913 F. W. Foster
 REGISTRAR

*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 <u>In Iowa</u>	DATE OF BURIAL _____, 191 <u>3</u>
UNDERTAKER	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 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.)

HUGH STEPHENS, JEFFERSON CITY,



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

ed. AGE should be carefully stated EXACTLY. PHYSICIANS should state occupation should be carefully stated EXACTLY. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Cass
Township Camp Branch
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

CERTIFICATE OF DEATH
Registration District No. 152 File No. _____
Primary Registration District No. 5216 Registered No. 4

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

FULL NAME Nelina Close

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan. 27, 1830
(Month) (Day) (Year)

AGE 82 yrs. 11 mos. 29 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 Wm. G. Rams
BIRTHPLACE OF FATHER Virginia
MAIDEN NAME OF MOTHER Anna Burkett
BIRTHPLACE OF MOTHER N. Carolina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. B. Chadd

(ADDRESS) Garden City, Mo.

Filed Jan 25 1913 F. H. Fortes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 24, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 16, 1913, to Jan. 24, 1913
that I last saw her alive on Jan. 24, 1913
and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:
Pneumonitis
(Duration) ___ yrs. ___ mos. 8 ds.

Contributory arteriosclerosis
(SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) P. D. Ramsey M. D.
1-25-1913 (Address) Garden City

*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 Iowa DATE OF BURIAL 1/24 1913

UNDERTAKER J. M. Kaufman ADDRESS Garden City

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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