

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.

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

PLACE OF DEATH

County Clark

Township DeMotte

Village St. Francisville

City (NO. _____) St. _____ Ward _____

Registration District No. 193

File No. 633

Primary Registration District No. 5470
5770

Registered No. 2

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

FULL NAME Marie Osa Carnes

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDWED OR DIVORCED child
(Write the word)

DATE OF BIRTH: May 24, 1910
(Month) (Day) (Year)

AGE 2 yrs. 7 mos. 22 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) 0

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

NAME OF FATHER Howey Carnes

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

MAIDEN NAME OF MOTHER Almeda Baley

BIRTHPLACE OF MOTHER (City or town, State or foreign country) St. Francisville Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howey Carnes

(ADDRESS) St. Francisville Mo.

Filed Jan 17, 1913, H. S. Reese
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 16, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 10, 1913, to Jan 16, 1913, that I last saw her alive on Jan 15, 1913, and that death occurred; on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

79B (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) H. O. Strohsneider M. D.
Jan 16, 1913 (Address) Wassau St

*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 Sand Cemetery DATE OF BURIAL Jan 17, 1913

UNDERTAKER H. E. Kieck ADDRESS Wayland Mo.

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 "*Asihenia*," "*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 septicæmia*," "*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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REGISTRARS SHALL NOT RE. BUREAU OF VITAL STATISTICS
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

CERTIFICATE OF DEATH

PLACE OF DEATH
County Clark
Township Hes Moines
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 193 File No. _____
Primary Registration District No. 5270 Registered No. 2

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

FULL NAME Marie Osa Carnes

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Child</u> (Write the word)	DATE OF DEATH <u>Jan. 16, 1913</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>May 24, 1910</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan. 10, 1913</u> to <u>Jan. 16, 1913</u> , that I last saw her alive on <u>Jan. 15, 1913</u> , and that death occurred, on the date stated above, at <u>4.30 a.m.</u>	
AGE <u>2</u> yrs. <u>7</u> mos. <u>22</u> ds.	if LESS than 1 day, ___ hrs. or ___ min.?		The CAUSE OF DEATH* was as follows: <u>Cerebro spinal meningitis</u> <u>no epidemic</u> *	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u>			(Duration) ___ yrs. ___ mos. ___ ds.	
(b) General nature of industry, business, or establishment in which employed (or employer)			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>St. Francisville</u>			(Signed) <u>H. O. Strosmider</u> M. D. <u>Jan. 16, 1913</u> (Address) <u>Vincent St.</u>	
PARENTS	NAME OF FATHER <u>Homer Carnes</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hancock Co. Ill.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Alvina Baley</u>		At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>St. Francisville Mo.</u>		Where was disease contracted If not at place of death? _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Homer Carnes</u>			Former or usual residence _____	
(ADDRESS) <u>St. Francisville Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>Sand Cemetery</u>	
Filed <u>Jan 17 1913</u> <u>H. S. Rees</u> M.D. REGISTRAR			DATE OF BURIAL <u>Jan. 17, 1913</u>	
			UNDERTAKER <u>H. F. Kincker</u> Wayland Mo.	

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association)

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