

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 | | MISSOURI STATE BOARD OF HEALTH | |
| BUREAU OF VITAL STATISTICS | | CERTIFICATE OF DEATH | |
| County <u>Oregon</u> | Registration District No. <u>1064</u> | File No. <u>2179</u> | |
| Township <u>Johnson</u> | Primary Registration District No. <u>5842</u> | Registered No. <u>1</u> | |
| Village _____ | City _____ (NO. _____) St. _____ | Ward _____ | |
| FULL NAME <u>Wm. Harned</u> | | | (If death occurred in a hospital or institution, give its NAME instead of street and number) |

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|---|--|---|---|--|
| SEX: <u>Female</u> | COLOR OR RACE: <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u> | DATE OF DEATH <u>Jan-15</u> , 191 <u>3</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>Jan-1</u> , 191 <u>3</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, | |
| AGE: _____ yrs. _____ mos. <u>15</u> ds. | | | that I last saw h_____ alive on _____, 191____, | |
| OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of Industry, business, or establishment in which employed (or employer) _____ | | | and that death occurred, on the date stated above; at <u>5 P.</u> m. | |
| BIRTHPLACE (City or town, State or foreign country) <u>Oregon Co - mo.</u> | | | The CAUSE OF DEATH* was as follows: <u>Not known</u> <u>No Physician in attendance</u> | |
| PARENTS | NAME OF FATHER <u>John Cisher</u> | IF LESS than 1 day, _____ hrs. or _____ min.? | Contributory _____ (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u> | | (Signed) <u>No Physicians</u> _____ M. D. | |
| | MAIDEN NAME OF MOTHER <u>Louisan Harris</u> | | _____ 191____ (Address) | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u> | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | |
| (Informant) <u>John Cisher</u> | | | At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | |
| (ADDRESS) <u>Fula mo.</u> | | | Where was disease contracted If not at place of death? | |
| Filed <u>1-16</u> , 191 <u>3</u> . <u>W. J. Boham</u> REGISTRAR | | | Former or usual residence _____ | |
| | | | PLACE OF BURIAL OR REMOVAL <u>Cannon Cemetery</u> | DATE OF BURIAL <u>1-16-</u> , 191 <u>3</u> |
| | | | UNDERTAKER <u>Dem Williams</u> | ADDRESS <u>Bradley mo.</u> |

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*, *Composer*, *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.)



PLACE OF DEATH

County

Oregon

Township

Johnson

or

Village

or

City

(NO.

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.

1064

File No.

Primary Registration District No.

5845
5482

Registered No.

1

St.

Ward)

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

FULL NAME

Unmanned

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

*w*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*S*

DATE OF BIRTH

*Jan 1**1913*

(Month)

(Day)

(Year)

AGE

15 yrs. *0* mos. *0* 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)

Oregon Mo

NAME OF FATHER

John Asher

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo

MAIDEN NAME OF MOTHER

Lillian Harris

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Asher

(ADDRESS)

Lula Mo.

Filed

1-16

1913

W. J. Cochran

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 15, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

, 191, to , 191,

that I last saw him alive on , 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

not known - no Phy. in attendance

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *No physician in attendance* M. D.

, 191 (Address)

*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

Concor Cem

DATE OF BURIAL

1/16, 1913

UNDERTAKER

Dan Williams

ADDRESS

Barley Mo

Original file, date

*JAN**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]

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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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