

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 Lancaster

Township _____

Village _____

City Jamesport (NO. _____)

Registration District No. 252

Primary Registration District No. 415-2

St. _____ Ward _____

File No. 4786

Registered No. 6

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

FULL NAME Caroline Matilda Houston

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 15, 1913
(Month) (Day) (Year)

DATE OF BIRTH July 22, 1858
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 15, 1913, to Feb 15, 1913, that I last saw her alive on Feb 14, 1913, and that death occurred, on the date stated above, at 9 a. m.

AGE 54 yrs. 6 mos. 11 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:
Paralysis of Heart

OCCUPATION (a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) None

Contributory Feb 16, 1913 (Duration) 5 min. yrs. mos. ds.

BIRTHPLACE (City or town, State or foreign country) Grundy Co Mo

(Signed) J. J. Harrison M. D.
Feb 16, 1913 (Address) Jamesport Mo

NAME OF FATHER Wm S Miller

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

MAIDEN NAME OF MOTHER Minerva Gray

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J Houston

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL 1007 Jamesport Mo DATE OF BURIAL Feb 16, 1913

UNDERTAKER W. R. Kingdon ADDRESS Jamesport Mo

Filed Feb 17, 1913 C. G. McKinley REGISTRAR

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

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

_____ (NO.) _____ St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)	AGE _____ yrs. _____ mos. _____ 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) _____

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) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

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

(Signed) _____ (Address) _____, 191____ M. D. (Duration) _____ yrs. _____ mos. _____ ds.

*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 _____	DATE OF BURIAL _____, 191____
UNDERTAKER _____	ADDRESS _____

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

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MISSOURI STATE BOARD OF HEALTH

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

PLACE OF DEATH
County Havassy
Township _____
or
Village _____
or
City amesport (NO. _____ St.: _____ Ward)

Registration District No. 252 File No. _____
Primary Registration District No. 4152 Registered No. 6

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m</u>
DATE OF BIRTH <u>July 22</u> , 1 <u>858</u> (Month) (Day) (Year)		
AGE <u>54</u> yrs. <u>6</u> mos. <u>15</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeping</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Gundy Co Mo</u>		
PARENTS	NAME OF FATHER <u>Wm S. Miller</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn</u>	
	MAIDEN NAME OF MOTHER <u>Margara Gray</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 15, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 15, 1913, to Feb 15, 1913, that I last saw h^e alive on Feb 14, 1913, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:
Paralysis of Heart

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory Fatty degeneration
(SECONDARY) (Duration) 2 yrs. _____ mos. _____ ds.

(Signed) G. D. Harris M. D.
Feb 16, 1913 (Address) Jamesport

*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
(Informant) Wm T Houston
(ADDRESS) Jamesport Mo

Filed Feb 17, 1913 W. R. Kingdon REGISTRAR

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>Old Hillm Co</u>	DATE OF BURIAL <u>Feb 16</u> , 191 <u>3</u>
UNDERTAKER <u>W. R. Kingdon</u>	ADDRESS <u>Jamesport</u>

Original file date FEB 1913, 19. 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, 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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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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 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.)