

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 Galles ✓
County Galles
Township Granth Registration District No. 242 File No. 8644
or Louisburg MO Primary Registration District No. 0335 Registered No. 3
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Susan Huckaby

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>	DATE OF DEATH <u>Feb 20</u> , 191 <u>3</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH <u>September 8th</u> , 18 <u>41</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>Jan 25th</u> , 191 <u>3</u> , to <u>Feb 20</u> , 191 <u>3</u> , that I last saw her alive on <u>Feb 15</u> , 191 <u>3</u> ,	
AGE <u>71</u> yrs. <u>5</u> mos. <u>12</u> ds.			and that death occurred, on the date stated above, at <u>12</u> m.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>			The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> <u>7:30</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Park Mo</u>			Contributory <u>Broncho-pneumonia</u> (SECONDARY) (Duration) <u>4</u> yrs. <u>21</u> mos. <u>21</u> ds.	
PARENTS	NAME OF FATHER <u>Duncan Shaw</u>		(Signed) <u>James A. Smith</u> M. D. <u>Feb 20</u> , 191 <u>3</u> (Address) <u>Park Mo</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
	MOTHER NAME OF MOTHER <u>Mary Ann Shraver</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. A. Shaw</u> (ADDRESS) <u>Huckaby</u>			Where was disease contracted if not at place of death? _____ Former or usual residence _____	
Filed <u>Mar 9</u> , 191 <u>3</u> <u>W. E. Gannon</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Hopewell</u> DATE OF BURIAL <u>Feb 21</u> , 191 <u>3</u>	
			UNDERTAKER <u>H. B. Rie</u> ADDRESS <u>Louisburg 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, peritonaeum*, 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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

Registration District No. 242 File No. _____
Primary Registration District No. 5330 Registered No. 3

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

FULL NAME Susan Huckaby

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept. 8, 1841
(Month) (Day) (Year)

AGE 71 yrs. 5 mos. 12 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) Pock Co. Mo.

PARENTS
NAME OF FATHER Huncan Shaw
BIRTHPLACE OF FATHER (City or town, State or foreign country) Jenn *
MAIDEN NAME OF MOTHER Margaret Thrower
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jenn *

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Show
(ADDRESS) Huckaby

Filed WAV 3 1913 W. E. Jamieson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 20, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 23, 1913, to Feb. 20, 1913, that I last saw her alive on Feb. 15, 1913, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs.

(Duration) 4 yrs. 21 ds.
Contributory Broncho pneumonia
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) James A. Little M. D.
Feb 20, 1913 (Address) Pock, 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 Hopewell DATE OF BURIAL Feb. 21, 1913

UNDERTAKER R. B. Rice ADDRESS* Louisburg

Original file, date MAR 1913, 1913. All information called for must be written on this Supplemental note

RECORD WITH UNFADING INK—THIS IS A PERMANENT RECORD

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