

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 Nodaway
Township Washington
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 623 File No. 10100
Primary Registration District No. 5825 Registered No. 7

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

FULL NAME Celestia Joslin

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If write the word)

DATE OF BIRTH October 29, 1858
(Month) (Day) (Year)

AGE 51 yrs. 11 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Epiphany Walker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Waverly, Mo.
MAIDEN NAME OF MOTHER Epiphany Walker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Waverly, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Epiphany Walker
(ADDRESS) _____

Filed Mar 5, 1913 AS Bamel
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 4, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 4, 1913, to March 4, 1913, that I last saw her alive on March 3, 1913, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH was as follows:
Pneumonia
8:15
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. ... M. D.
Mar 5, 1913 (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 Gulfport, Mo DATE OF BURIAL 3/6, 1913
(UNDERTAKER) Reynolds Brittain ADDRESS Gulfport, 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, 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.)



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

PLACE OF DEATH Madaway REGISTRARS SHALL NOT RE-
County Washington CEIVE A FEE FOR CERTIFICATES
Township Washington UNTIL THEY ARE COMPLETED AS
or Washington PRESCRIBED BY LAW.
Village _____ Registration District No. 623 File No. _____
or _____ Primary Registration District No. 5825 Registered No. 7
City _____ (NO. _____) St. _____ Ward _____
FULL NAME Celestia Jollin [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 Fem. COLOR OR RACE W. SINGLE Widowed
MARRIED
OR DIVORCED
(Write the word)

DATE OF DEATH Feb 11 1913
(Month) (Day) (Year)

DATE OF BIRTH October 29 1858
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Jan 1, 1913, to Feb 4, 1913,
that I last saw her alive on Feb 3, 1913,

AGE 57 yrs. 4 mos. 5 ds.
If LESS than
1 day, ____ hrs.
or ____ min.

and that death occurred, on the date stated above, at 9 a.m.

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

The CAUSE OF DEATH* was as follows:
Paralysis
acute ascending

BIRTHPLACE near Kansas City Mo
(City or town, State or foreign country)

(Duration) _____ yrs. _____ mos. 9 ds.

PARENTS NAME OF FATHER Wm. B. Benge

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

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

(Signed) J. M. McLaughlin, M. D.
Feb 5 1913 (Address) Sulford Mo.

MAIDEN NAME OF MOTHER Bertha Stegell

*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 MOTHER Ind
(City or town, State or foreign country)

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vernie Jollin

Where was disease contracted
If not at place of death? _____
Former or usual residence _____

(ADDRESS) Clyde Mo.

PLACE OF BURIAL OR REMOVAL Sulford Mo. DATE OF BURIAL 3/6 1913

Filed March 3 1913 W. B. Benge
REGISTRAR

UNDERTAKER Reynolds Brothers ADDRESS Sulford Mo.

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02100
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.)