

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 Texas
Township Burdick
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 862 File No. 11914
Primary Registration District No. 6135 Registered No. 8

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

FULL NAME Eliza J. Hoffman

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Mar 18 1850
Mar 18 1913
(Month) (Day) (Year)

AGE 63 yrs. 1 mos. 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) -9-0

BIRTHPLACE (City or town, State or foreign country) Tenn

NAME OF FATHER Mannon X

BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know X

MAIDEN NAME OF MOTHER don't know X

BIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know X

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Beatt
(ADDRESS) Cabool Mo

Filed Mar 15 1913 J. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 13, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 6, 1913, to Mar 8, 1913, that I last saw her alive on Mar 8, 1913, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Strangulated hernia

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

(Signed) J. R. Patton M. D.
Mar 14 1913 (Address) Cabool 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 Cabool Cemety DATE OF BURIAL Mar 15 1913

UNDERTAKER W. R. Clifton ADDRESS Cabool 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.)



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PLACE OF BIRTH _____

County Texas
 Township Burdieu
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 862 File No. 37
 Primary Registration District No. 6135 Registered No. 8

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

FULL NAME Eliza J. Huffman

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
 (Write the word)
 DATE OF BIRTH March 18, 1850
 (Month) (Day) (Year)
 AGE 63 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 13, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from March 6, 1913, to March 8, 1913, that I last saw her alive on March 8, 1913, and that death occurred, on the date stated above, at 11:05 P.M.

OCCUPATION (a) Trade, profession, or particular kind of work

Housewife

The CAUSE OF DEATH* was as follows:

Strangled hernia

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country)

Don't know

NAME OF FATHER

Don't know

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

Don't know

MAIDEN NAME OF MOTHER

Don't know

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

Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. I. Scott
 (ADDRESS) Labool, Mo.

Contributory (SECONDARY)

(Signed) J. W. Patton M. D.
Mar 14, 1913 (Address) Labool, 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

Labool Cemetery

DATE OF BURIAL

Mar 15, 1913

UNDERTAKER

W. P. Lelifton

ADDRESS

Labool, Mo.

Filed Mar 15 1913 J. A. Robertson REGISTRAR

MAR 1913

Original file, date _____

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 carbonic 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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