

WHILE 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 Clinton  
or  
Village ~~Dallas~~  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 1027 File No. 11937  
Primary Registration District No. 6130 Registered No. 13  
St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME Margaret Hall

PERSONAL AND STATISTICAL PARTICULARS

|   |  |   |
|---|--|---|
| SEX<br>↓  | COLOR OR RACE<br><u>white</u>  | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(If ride the word) |
| DATE OF BIRTH<br><u>Apr 11 1884</u><br>(Month) (Day) (Year)   |  |   |
| AGE<br><u>73</u> yrs. <u>10</u> mos. <u>17</u> ds.  |  | IF LESS than<br>1 day, ___ hrs.<br>or ___ min.?                   |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Housewife</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u> |  |   |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Gilman Allegheny Co Pennsylvania</u>  |  |   |
| -PARENTS  | NAME OF FATHER<br><u>Peter Zimmerman</u>   |   |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Pennsylvania</u> |   |
|   | MAIDEN NAME OF MOTHER<br><u>Not known</u>  |   |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Pennsylvania</u> |   |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 28 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2/24, 1913, to 2/28, 1913, that I last saw he alive on 2/28, 1913, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:  
Senile Pneumonia  
109A

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)  
8 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. M. D.  
(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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Maggie L. Lightner  
(ADDRESS) Mountain Grove Mo  
Filed March 1 1913 J. D. Weatherman  
REGISTRAR

|                                   |                                     |
|-----------------------------------|-------------------------------------|
| PLACE OF BURIAL OR REMOVAL<br>↓   | DATE OF BURIAL<br><u>Mar 1 1913</u> |
| UNDERTAKER<br><u>J. W. Mathis</u> | ADDRESS<br><u>Mo. 900</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*, *Sarcoma*, 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.)

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.

RECORD WITH CHANGING LINK—THIS IS A PERMANENT RECORD

PLACE OF BIRTH \_\_\_\_\_

Texas  
Clinton

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

County \_\_\_\_\_  
Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) \_\_\_\_\_  
Registration District No. 1027 File No. 11927  
Primary Registration District No. 6126 Registered No. 13

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

FULL NAME Margarett Hall

| PERSONAL AND STATISTICAL PARTICULARS  |  |   |
|---|--|---|
| SEX<br><u>Female</u>  | COLOR OR RACE<br><u>W.</u>   | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)<br><u>Widow</u> |
| DATE OF BIRTH<br><u>Apr. 11, 1834</u><br>(Month) (Day) (Year)   |  |   |
| AGE<br><u>72</u> yrs. <u>10</u> mos. <u>17</u> ds.  |  | IF LESS than 1 day, _____ hrs. or _____ min.                        |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |  |   |
| BIRTHPLACE<br>(City or town, State or foreign country) _____  |  |   |
| PARENTS   | NAME OF FATHER _____   |   |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) _____ |   |
|   | MAIDEN NAME OF MOTHER _____  |   |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) _____ |   |

| MEDICAL CERTIFICATE OF DEATH   |  |  |
|--|--|--|
| DATE OF DEATH<br><u>2</u> <u>28</u> 19 <u>13</u><br>(Month) (Day) (Year)   |  |  |
| I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, and that death occurred, on the date stated above at _____ m.                                     |  |  |
| The CAUSE OF DEATH* was as follows:<br>_____   |  |  |
| _____<br>(Duration) _____ mos. _____ ds.   |  |  |
| Contributory<br>(SECONDARY) _____<br>(Duration) _____ yrs. _____ mos. _____ ds.  |  |  |
| (Signed) _____ M. D.<br>_____ 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)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. |  |  |
| Where was disease contracted<br>If not at place of death? _____  |  |  |
| Former or usual residence _____  |  |  |

SUPPLEMENTARY Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Charles E. Hall  
(ADDRESS) Mountain Grove Mo  
Filed 3-1-13 1913 J. D. Meathunter  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Greenwood Cem DATE OF BURIAL 3-1 1913  
UNDERTAKER Satisfactory Information Supplied. ADDRESS \_\_\_\_\_

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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.)