

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH ~~11309~~  
~~11309~~  
11329 ~~11329~~

PLACE OF DEATH  
County Texas  
Township Dale  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 1097 File No. \_\_\_\_\_  
Primary Registration District No. 6142 Registered No. \_\_\_\_\_

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

FULL NAME Mary Lane Graves

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE American SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Aug 4, 1889  
(Month) (Day) (Year)  
AGE 79 yrs. 7 mos. 7 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Keeping  
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

BIRTHPLACE (City or town, State or foreign country) Cilagro Co Ohio

PARENTS  
NAME OF FATHER James H. Gilson  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Harrisonville Ohio  
MAIDEN NAME OF MOTHER not known as she died when young  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) M. F. Graves  
(ADDRESS) Refined Ave.  
Mar 13, 1930 W. G. Thom  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 11, 1930  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from 11, 1930, to 11, 1930, that I last saw her alive on 8, 1930, and that death occurred, on the date stated above, at 1 m.  
The CAUSE OF DEATH\* was as follows:

Cerebro Apoplexy  
22A

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) W. E. DeTromet M. D.  
April 7, 1930 (Address) Summersville 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 Arnold Cemetery DATE OF BURIAL Mar 12, 1930  
UNDERTAKER Mr. One Kinney ADDRESS Arnold

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**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

[If death occurred  
 hospital or insti-  
 tute, give its NAME  
 of street and num-  
 ber.]

St. \_\_\_\_\_ Ward \_\_\_\_\_

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
 SINGLE  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 IF LESS THAN  
 1 day, \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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)

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) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ (Duration) \_\_\_\_\_

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ (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. 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 \_\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

PLACE OF DEATH

County Texas  
Township Date  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 1097 File No. \_\_\_\_\_  
Primary Registration District No. 6162 Registered No. 1

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

FULL NAME Mary Jane Graves

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED widowed WIDOWED OR DIVORCED (If write the word)  
DATE OF BIRTH August 4, 1889  
(Month) (Day) (Year)  
AGE 73 yrs. 7 mos. 7 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

DATE OF DEATH March 11, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 8, 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 4 P.M.

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

The CAUSE OF DEATH\* was as follows:  
Cerebro Apoplexy  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Magnolia, Ohio  
NAME OF FATHER Jas. W. Wilson  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Harrisonville, Ohio  
MAIDEN NAME OF MOTHER Not known  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) W. E. De Forest M. D. Apr. 7, 1913, (Address) Summersville, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) C. J. Graves  
(ADDRESS) Putlick, Mo.

PLACE OF BURIAL OR REMOVAL Arroll Cemetery DATE OF BURIAL March 12, 1913  
UNDERTAKER Mr. McKimney ADDRESS Arroll, Mo.

Filed Mar 30 1913 M. G. Throp REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. If cause of death is not known, it should be so stated. If death occurred in a hospital or institution, give its name instead of street and number. Exact statement of OCCUPATION is very important.

# 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*, *peritoneum*, 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.)

11929