

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 12126

PLACE OF DEATH

County Barton

Township _____
or _____
Village _____
or _____
City Lamar (NO. _____ St. _____ Ward _____)

Registration District No. 40
Primary Registration District No. 4024

File No. 12626
Registered No. 11

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

FULL NAME Elizabeth Harney Richardson

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH 11 4 1843
(Month) (Day) (Year)

AGE 70 yrs. 5 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

PLACE OF BIRTH (City or town, State or foreign country) Sidney, Ohio

NAME OF FATHER Mr. Harney

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

MAIDEN NAME OF MOTHER Unknown

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

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

(ADDRESS)

Subscribed and sworn to before me on Apr. 8, 1913, at Hoyt Humphrey, Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4 7 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 2nd, 1913, to Apr 2nd, 1913, that I last saw her alive on Apr 2nd, 1913, and that death occurred, on the date stated above, at 7 P.M. The CAUSE OF DEATH* was as follows:

Septicemia & Duodenal Stenosis
(Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) G. S. Wolford M. D. 4/8, 1913 (Address) Lamar 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 Sidney Ohio DATE OF BURIAL _____ 1913

UNDERTAKER Hoyt Humphrey ADDRESS Lamar Mo

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

PLACE OF DEATH

County _____
 Township _____ File No. _____
 or _____
 Village _____ Primary Registration District No. _____ Registered No. _____
 or _____
 City _____ (NO. _____) St.: _____ Ward _____

If death occurred
 hospital or instit.
 give its NAME in
 of street and numbe

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?
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)	1913. 11. 4 1848 11 4 70 1 5 3
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) _____, 19____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

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

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ M. _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 19____

UNDERTAKER _____ ADDRESS _____

PLACE OF DEATH

County Barton

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

Township _____ or Village _____ or City Lamar (NO. _____ St. _____ Ward _____)

Registration District No. 40

File No. _____

Primary Registration District No. 4024

Registered No. 11

FULL NAME

Elizabeth Hanev Richardson

(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 F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M. (If write the word)

DATE OF DEATH 4 7, 1913
(Month) (Day) (Year)

DATE OF BIRTH 11 4, 1843
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from _____, 1913, to _____, 1912, and that I last saw her alive on _____, 1913, and that death occurred, on the date stated above, at _____.

AGE 70 yrs. 5 mos. 3 ds. IF LESS than 1 day, _____ hrs or _____ min.

The CAUSE OF DEATH* was as follows:
Quinolinal Stenosis.

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

(The doctor positively refuses to give any further information. He says he don't get any pay for making out a death certificate)
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Sidney Ohio

NAME OF FATHER Wm. H. Richardson

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

MAIDEN NAME OF MOTHER _____

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

(Signed) L. B. Wolford M. D.
4/8 1913 (Address) Lamar Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. W. Richardson

*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 Satisfactory Information Supplied

(ADDRESS) Lamar, Mo.

PLACE OF BURIAL OR REMOVAL Sidney Ohio DATE OF BURIAL _____ 1913

Filed Apr. 8 1913 C. L. McComb REGISTRAR

UNDERTAKER Hoyt Humphrey ADDRESS Lamar Mo.

Original file date APR - 1913

All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plaintext, but it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Satisfactory Information Supplied

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, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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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.)