

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 12202

PLACE OF DEATH
County Boonville
Township _____
or
Village _____
or
City Columbia (NO. _____) St. _____ Ward _____
Registration District No. 700 File No. 12-62
Primary Registration District No. 3006 Registered No. 57

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

FULL NAME Susie Sella Stewart

PERSONAL AND STATISTICAL PARTICULARS

SEX MALE FEMALE
COLOR OR RACE WHITE COLORED
SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)
DATE OF BIRTH January 22, 1886
(Month) (Day) (Year)
AGE 27 yrs. 5 mos. 5 ds.
If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE:
City or town, State or foreign country Columbia Mo

PARENTS
NAME OF FATHER S. G. Lipton
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo. Hann
MAIDEN NAME OF MOTHER Ella W. H. H.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. O. Muench
(ADDRESS) Columbia Mo

Filed 4/18 1913 AW Kaufschmidt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 17, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 14, 1913, to April, 1913, that I last saw him alive on April 17, 1913, and that death occurred, on the date stated above, at 7:38 p. m.

The CAUSE OF DEATH* was as follows:
General peritonitis following palpates.
130 B
170 (Duration) _____ yrs. _____ mos. 20 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) AW Kaufschmidt M. D.
4/18, 1913 (Address) Columbia 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 RESIDENCE) Parker Hosp.
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 Columbia Cem. DATE OF BURIAL 4/18 1913
BURIAL TAKER Parker Fun B ADDRESS Columbia

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*, *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

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

PLACE OF DEATH
 County Boone Registration District No. 73 File No. _____
 Township _____ or Village _____ or City Columbia (NO. _____ St. _____ Ward _____)
 Primary Registration District No. 3006 Registered No. 51

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

FULL NAME Susie Stella Stewart

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
 DATE OF BIRTH Jan. 27, 1886 (Month) (Day) (Year)
 AGE 27 yrs. 2 mos. 26 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) _____

PARENTS 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) AW Kampschmidt (ADDRESS) Columbia Mo.

Filed 10/23 1913 AW Kampschmidt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4 17, 1913 (Month) (Day) (Year)

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

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 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). At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds. Where was disease contracted If not at place of death? Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied DATE OF BURIAL _____, 191____ ADDRESS _____ UNDERTAKER _____

SUPPLEMENTARY Satisfactory Information Supplied.

MARGIN RESERVED FOR BINDING

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Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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