

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Cooper
Township Kelly
or
VillageRegistration District No. 219 File No. 12602
Primary Registration District No. 5299 Registered No. 4

(NO. _____ St.: _____ Ward)

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

FULL NAME Gertrude Sponcer

PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE white SINGLE MARRIED OR DIVORCED single
AGE AT DEATH 31 yrs. 16 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?
DATE OF BIRTH Jan 31, 1913OCCUPATION, trade, profession, or regular kind of work baby
General nature of industry, business, or establishment in which employed (or employer) 0-0PLACE OF BIRTH (City or town, State or foreign country) Cooper Co. MoNAME OF FATHER Wm SponcerBIRTHPLACE OF FATHER (City or town, State or foreign country) Cooper Co. MoMAIDEN NAME OF MOTHER Grace BullBIRTHPLACE OF MOTHER (City or town, State or foreign country) Cooper Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm R. Roberts(ADDRESS) Tipton, MoSigned Apr 10 1913 J. M. Robertson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 15, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from July 13, 1913, to July 10, 1913, that I last saw her alive on July 15, 1913, and that death occurred, on the date stated above, at noon m.

The CAUSE OF DEATH* was as follows:

Pneumonia
10 (Duration) yrs. mos. 4 ds.

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

(Signed) J. E. Williams M. D. July 15, 1913 (Address) Tipton, 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 L. Patterson & Son DATE OF BURIAL Feb. 16, 1913UNDERTAKER L. Patterson & Son ADDRESS Tipton, Mo

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward _____

[If death occurs in hospital, give its name and street address.]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	(Month) _____ (Day) _____ (Year) _____
DATE OF BIRTH _____	IF LESS than 1 day _____ hrs. or _____ min.?	_____ mos. _____ ds.	_____ yrs. _____ mos. _____ ds.
AGE _____	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 _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____

(Day) _____

I HEREBY CERTIFY, that I attended death.

that I last saw h_____ alive on _____, 191____, to _____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos. _____

(Duration) _____ yrs. _____ mos. _____

Contributory

(Secondary)

(Signed) _____

191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAINING SCHOOLS, ETC.)

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 _____

UNDERTAKER _____

ADDRESS _____

PLACE OF DEATH

County

Copier Kelly

Township

or Village

or City

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

Registration District No.

219

File No.

Primary Registration District No.

3299

Registered No.

4

(NO.

St.

Ward)

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

FULL NAME

Gertrude Spangler

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

S

DATE OF BIRTH

1-31 1913

AGE

16 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)

Mo.

NAME OF FATHER

Wm. Spangler

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

Mo.

MAIDEN NAME OF MOTHER

Agnes Bell

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

Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. Monso.

(ADDRESS)

Lepta

Filed

April 10 1913

REGISTRAR

J. M. Robertson

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

2/15 1913

I HEREBY CERTIFY, that I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

P. Broncho-neumonia

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

P. E. Williams

M. D.

April 10 1913 (Address) *Lepta 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

DATE OF BURIAL

Buried in

2/16 1913

UNDERTAKER

ADDRESS

Patterson Lepta

Lepta

Original file, date

APR 1913

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

N. B. ... CIVIL SUPPLEMENTARY

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.)

PLACE OF DEATH

County Leavenworth
 Township Kelley
 Village _____
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 219 File No. _____
 Primary Registration District No. 5299 Registered No. 4

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

FULL NAME Gertrude Sponcer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Jan. 31, 1913</u> <small>(Month) (Day) (Year)</small>		
AGE _____ yrs. _____ mos. <u>16</u> 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) Satisfactory Information Supplier
 (ADDRESS) _____

Filed April 10 1913. J. M. Robertson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb- 15, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-13, 1913, to 2-15, 1913, that I last saw her alive on 2-15, 1913,

and that death occurred, on the date stated above, at noon m.

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

Contributory (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) P. E. Williams M. D.
Feb- 15, 1913 (Address) Tipton 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. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL <u>Burgess Mo.</u>	DATE OF BURIAL <u>Feb 16 1913</u>
UNDERTAKER <u>Satisfactory Information Supplier</u>	ADDRESS <u>Bayston Mo.</u>

Satisfactory Information Supplied.
SUPPLEMENTARY
 Satisfactory Information Supplied.

N. B.—Every entry of information should be carefully supplied. AGE should be stated EXACTLY. REGISTRARS should state the CAUSE OF DEATH if it is not stated on the certificate. If it is not stated, it should be properly classified. Exact statement of OCCUPATION is very important.

WRITE IN

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*.

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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.)

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