

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.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH	
County <u>Cent</u>		BUREAU OF VITAL STATISTICS	
Township <u>Brickier</u>		Registration District No. <u>265</u>	File No. <u>12675</u>
Village _____		Primary Registration District No. <u>5368</u>	Registered No. <u>10</u>
City _____ (NO. _____)		St. _____	Ward _____
FULL NAME <u>Sarah</u>		<u>Wepeland</u>	

(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 <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>April</u> <u>21</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Dec 5th</u> , 18 <u>41</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
AGE <u>72</u> yrs. <u>3</u> mos. <u>27</u> ds. if LESS than 1 day, ____ hrs. or ____ min.?			that I last saw her alive on <u>Feb 11</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>2:00</u> a.m.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u>			The CAUSE OF DEATH* was as follows: <u>Carcinoma</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>House work</u>			<u>50</u> <u>53</u> (Duration) ____ yrs. ____ mos. ____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Iron Co Mo</u>			Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.	
PARENTS	NAME OF FATHER <u>Berg McNeal</u>		(Signed) <u>J. R. Gordon</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>State Mo.</u>		<u>April 1, 1913</u> (Address) <u>Banker Mo</u>	
	MAIDEN NAME OF MOTHER <u>Salvina Spout</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>State Mo.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Pat Gordon</u> (ADDRESS) <u>Gila Mo</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>April 21, 1913</u> <u>J. R. Gordon</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Day Cemetery</u>	
			DATE OF BURIAL <u>April 2, 1913</u>	
			ADDRESS <u>Gila Mo</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*, *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*, *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

PLACE OF DEATH

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

County De Witt
Township Lincoln
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 265 File No. _____
Primary Registration District No. 5368 Registered No. 10

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

FULL NAME Sarah Copeland

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <i>(Write the word)</i>
DATE OF BIRTH <u>Dec 5, 1841</u> <i>(Month) (Day) (Year)</i>		
AGE <u>72 yrs 3 mos 27 da.</u>		IF LESS than 1 day, <u>hrs</u> or <u>mins</u>
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housewife</u>		
BIRTHPLACE <u>Iron Co Mo</u> <i>(City or town, State or foreign country)</i>		
PARENTS	NAME OF FATHER <u>Berj M. Staut</u>	
	BIRTHPLACE OF FATHER <u>Mo</u> <i>(City or town, State or foreign country)</i>	
	MAIDEN NAME OF MOTHER <u>Sarah Staut</u>	
	BIRTHPLACE OF MOTHER <u>Mo</u> <i>(City or town, State or foreign country)</i>	

DATE OF DEATH Apr 1, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____ to _____, 191____, and 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:
Carcinoma Left Breast and Axillary Glands

Contributory _____
(Secondary)

(Signed) J. H. Gordon M. D.
H. P. 1913 (Address) Bunker Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pat Gordon
(ADDRESS) Bunker Mo

Filed April 1, 1913 J. H. Gordon X
REGISTRAR

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

Where was disease contracted if not at place of death? at place of death

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Bay Cemetery DATE OF BURIAL April 2, 1913

UNDERTAKER H. H. Gray ADDRESS St. Louis Mo

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

512075

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