

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

PLACE OF DEATH Lafayette
County Lafayette Registration District No. 461 File No. 13592
Township Douglas or Village _____ Primary Registration District No. 5025 Registered No. 152
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Margaret Jane Goodbrake

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>
DATE OF BIRTH <u>August 29, 1887</u> <small>(Month) (Day) (Year)</small>		
AGE <u>75</u> yrs. <u>8</u> mos. <u>6</u> ds. <small>if LESS than 1 day, hrs. or min.?</small>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired 9-0</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housewife</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>James Bristol</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Stuten</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Indiana</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 5, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 18, 1912 to March 3, 1913, that I last saw him alive on March 3, 1913, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:
Renal Hemorrhage
8 yrs.
8 yrs.

Contributory Old age
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. C. Young M. D.
Wellington
1913 (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 State yrs. mos. ds.

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

PLACE OF BURIAL OR REMOVAL Wellington Mo DATE OF BURIAL Mar 7, 1913
UNDERTAKER Ernest H. H. H. H. ADDRESS Wellington Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Goodbrake
(ADDRESS) Wellington Mo

Filed Apr 8⁵ 1913 G. H. H. H. REGISTRAR

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*, *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 surgi al 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 Lafayette
 Township Lexington
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

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

Registration District No. 461 File No. _____
 Primary Registration District No. 5625 Registered No. 152

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

FULL NAME

Margaret Jane Goodbrake

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED. W.
 (Write the word)

DATE OF BIRTH Aug. 29th, 1837
 (Month) (Day) (Year)

AGE 75 yrs. 8 mos. 6 ds. If LESS than
 1 day, ___ hrs
 or ___ min.

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

BIRTHPLACE
 (City or town,
 State or foreign country) Indiana

PARENTS
 NAME OF FATHER James Briston
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana
 MAIDEN NAME OF MOTHER Eizabeth Staten
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) l. F. Goodbrake

(ADDRESS) Lexington Mo.

Filed 4/8 1938 J. H. Kendrick
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar. 5th, 1938
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
April 18, 1937, to March 5, 1938,
 that I last saw h. en alive on 3, 1938,
 and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Haemiplegia

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

Contributory Old age. 66
 (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. A. Mann M. D.
3/5 1938 (Address) Wellington

*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 Lexington Mo. DATE OF BURIAL 3/7 1938

UNDERTAKER Ernest Fugert ADDRESS Lexington Mo.

Original file, date 3/16 AK 1938 All information called for must be written on this Supplementary Certificate.

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Revised United States Standard Certificate of Death

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

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