

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

PLACE OF DEATH  
County Pettis  
Township Smithton Registration District No. 669 File No. 14021  
Village \_\_\_\_\_ Primary Registration District No. 5892 Registered No. 6  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Ludley Mosby

**PERSONAL AND STATISTICAL PARTICULARS**

SEX M COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Mar 2 1873  
(Month) (Day) (Year)

AGE 40 yrs. 1 mos. 21 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) Go D

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

PARENTS  
NAME OF FATHER John Watters  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.  
MAIDEN NAME OF MOTHER Hattie Thomas  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. M. Parrish  
(ADDRESS) Sedalia Mo.

Filed Apr 28 1913 S. M. Parrish  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH April 23 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 11, 1913, to April 22, 1913, that I last saw her alive on April 22, 1913, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia

108  
82 B (Duration) yrs. mos. 28 ds.

Contributory Cerebral embolism  
(SECONDARY) (Duration) yrs. mos. 3 ds.  
(Signed) Edw A Albus M. D.  
(Address) Sedalia 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 that Creek Church DATE OF BURIAL 4-24 1913

UNDERTAKER Sedalia ADDRESS Sedalia

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.

*Dr. Albus*

**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**

County.....  
 Township..... File No.....  
 or.....  
 Village..... Registered No.....  
 or.....  
 City.....(NO.....) St.:..... Ward)  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**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).....

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH....., 191..... (Month)..... (Day)..... (Year).....  
 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:  
 .....

**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).....

(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. 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..... 191.....  
 UNDERTAKER..... ADDRESS.....

Filed....., 191..... REGISTRAR.....

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 Pettis  
County Smithton Registration District No. 669 File No. \_\_\_\_\_  
Township \_\_\_\_\_ or \_\_\_\_\_  
Village \_\_\_\_\_ Primary Registration District No. 5892 Registered No. 6  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Luley Mosby

PERSONAL AND STATISTICAL PARTICULARS

SEX Satisfactory information supplied. COLOR OR RACE \_\_\_\_\_ SINGLE MARRIED WIDOWED OR DIVORCED \_\_\_\_\_  
DATE OF BIRTH Satisfactory information supplied.  
AGE Satisfactory information supplied. 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 supplied.  
(ADDRESS) \_\_\_\_\_  
Filed X 1913 S. M. Parvost REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4 23 1913  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw h. \_\_\_\_\_ alive \_\_\_\_\_, 191\_\_\_\_,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia Lobar  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 28 ds.  
Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) E. A. Galt M. D. (Address) Archie  
\*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 Satisfactory information supplied. DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS Satisfactory information supplied.

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, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, 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 septicæmia," "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.)

13041