

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 Wright
Township Montgomery
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 911 File No. 15583
Primary Registration District No. 6227 Registered No. 5

FULL NAME Sarah Woodard

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white MARRIED married
OR DIVORCED (Write the word)

DATE OF BIRTH Oct. 15th 1858
(Month) (Day) (Year)

AGE 54 yrs. 5 mos. 29 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) general house work

BIRTHPLACE (City or town, State or foreign country) North Carolina

PARENTS
NAME OF FATHER Isiah Rose
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER Rose
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 14th 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 19th March 1913, to April 11, 1913, that I last saw her alive on April 11, 1913, and that death occurred, on the date stated above, at 12³⁰ am.
The CAUSE OF DEATH* was as follows:
Enlargement of Tumor on Liver
H6E

(Duration) 3 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Carraway M. D.
(Address) Manassas Md.

*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? at Place of death
Former or usual residence 40 years at Place of death

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 1913

UNDERTAKER ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah Woodard
(Address) Manassas Md.

Filed Apr 26 1913 Geo B. Geiss
REGISTRAR

United States Standard Certificate
of Death

Missouri

County

Bureau of American Public Health
(Association)

tion.—Precise statement of occupation, so that the relative health-conditions can be known. The question every person, irrespective of sex, should answer with a single word or term on the certificate, e. g., *Farmer* or *Planter*, *Architect*, *Locomotive engineer*, *Fireman*, etc. But in many cases, especially in manual or industrial employments, it is necessary to state (a) the kind of work and also (b) the industry, and therefore an addition is needed for the latter statement; it is as follows: As examples: (a) *Salesman*, (b) *Grocery*; (c) *Mobile factory*. The material part of the second statement is: "Foreman," "Manager," "Supervisor," etc. For more precise specification, as in *Foreman—Coal mine*, etc. For persons engaged in the duties of the household, as *Housekeepers* who receive no wages, enter as *Housewife*, *Housemaid*, *Children*, not gainfully employed. Care should be taken to state the occupation of persons engaged in domestic service, as *Servant*, *Cook*, *Housekeeper*, etc. If occupation has been changed or given up, state the cause CAUSING DEATH, state of health. If retired from business, indicate thus: *Farmer* (retired), etc. For persons who have no occupation

of death.—Name, first, the primary affection with relation to the cause of death, using always the same term for the same disease. Examples: *Cere-*

brospinal 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

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

PLACE OF DEATH
County Wright
Township Montgomery
Village _____
City _____ (NO. _____)

Registration District No. 911 File No. _____
Primary Registration District No. 6227 Registered No. 5
St. _____ Ward _____

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

FULL NAME Sarah Woolard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M.
(If wife, the word)

DATE OF DEATH Apr. 14, 1913
(Month) (Day) (Year)

DATE OF BIRTH Oct. 15, 1858
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 19th of Feb., 1913, to Apr. 11, 1913,
that I last saw her alive on " 11 ", 1913

AGE 54 yrs. 5 mos. 29 ds.
If LESS than 1 day, ___ hrs. or ___ min.

and that death occurred, on the date stated above, at 12:30 a. m.

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

The CAUSE OF DEATH* was as follows:
Enlargement of Tumor on Liver malignant

BIRTHPLACE
(City or town, State or foreign country) N. Carolina

(Duration) 3 yrs. ___ mos. ___ ds.

PARENTS
NAME OF FATHER Isabel Rose
BIRTHPLACE OF FATHER Not known
MAIDEN NAME OF MOTHER Rose
BIRTHPLACE OF MOTHER Not known

Contributory (Secondary) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. Evans M. D.
April 4, 1913 (Address) Manes Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Steve Woolard
(ADDRESS) Manes 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 _____

Filed Apr 20, 1913 J. G. Cook REGISTRAR

PLACE OF BURIAL OR REMOVAL Base Cemetery DATE OF BURIAL _____ 1913
UNDERTAKER Wright ADDRESS Manes Mo.

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.

THIS IS A SUPPLEMENTARY RECORD

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) *Colton 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*;

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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