

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

County Saline  
 or  
 Township Marshall  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

46<sup>83</sup>

V

796

18627

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. 6039 Registered No. 47

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

FULL NAME Melissa C. Donnell

| PERSONAL AND STATISTICAL PARTICULARS  |   |  | MEDICAL CERTIFICATE OF DEATH   |  |
|---|---|--|--|--|
| SEX<br><u>F.</u>  | COLOR OR RACE<br><u>W</u>   | MARRIAGE STATUS<br><u>Widowed</u><br><small>(Write the word)</small> | DATE OF DEATH<br><u>May 15</u> , 191 <u>3</u><br><small>(Month) (Day) (Year)</small>   |  |
| DATE OF BIRTH<br><u>June 4</u> , 18 <u>42</u><br><small>(Month) (Day) (Year)</small>  |   |  | I HEREBY CERTIFY, that I attended deceased from <u>Feb 6</u> , 191 <u>3</u> , to <u>May 15</u> , 191 <u>3</u> , that I last saw h <u>4</u> alive on <u>May 12</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:<br><br><u>Epilepsy</u> |  |
| AGE<br><u>70</u> yrs. <u>11</u> mos. <u>12</u> ds.<br><small>IF LESS than 1 day, ___ hrs. or ___ min.?</small>  |   |  |  |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)<br><u>Inmate of County farm</u>   |   |  | Contributory _____<br><small>(SECONDARY)</small><br><small>(Duration) ___ yrs. ___ mos. ___ ds.</small>  |  |
| BIRTHPLACE<br>(City or town, State or foreign country)<br><u>MO</u>   |   |  |  |  |
| PARENTS   | NAME OF FATHER<br><u>Thos Coy</u>   |  | Signed) <u>A G Bone</u> M. D.<br><u>May 16</u> , 191 <u>3</u> (Address) <u>Marshall Mo</u>   |  |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country)<br><u>Mo</u>         |  |  |  |
|   | MAIDEN NAME OF MOTHER<br><u>Elizabeth Ham</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<br>(City or town, State or foreign country)<br><u>Don't know</u> |  |  |  |
| LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.<br>Where was disease contracted if not at place of death?<br>Former or usual residence _____ |   |  |  |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Will G. Donnell</u><br>(ADDRESS) <u>Marshall Mo</u>   |   |  |  |  |
| Filed <u>May 11</u> , 191 <u>3</u> . <u>A G Dittman</u><br>REGISTRAR  |   |  | PLACE OF BURIAL OR REMOVAL<br><u>Ridge Park C</u><br>DATE OF BURIAL<br><u>May 16</u> , 191 <u>3</u><br>UNDERTAKER<br><u>Campbell &amp; Shupe</u><br>ADDRESS<br><u>Marshall 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, 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, peritonaeum*, 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 Saline  
 Township Marshall  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 796 File No. \_\_\_\_\_  
 Primary Registration District No. 6039 Registered No. 47

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

FULL NAME Malissa O'Donnell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE MARRIED Applied.  
Satisfactory Information Supplied.  
 OR WIDOWED OR DIVORCED (Write the word)  
 DATE OF BIRTH \_\_\_\_\_  
Satisfactory Information Supplied.  
 (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 AGE \_\_\_\_\_  
Satisfactory Information Supplied.  
 IF LESS than \_\_\_\_\_ day, \_\_\_\_\_ hrs \_\_\_\_\_ min.  
 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.

DATE OF DEATH \_\_\_\_\_  
May 15, 1913  
 (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_  
Satisfactory Information Supplied.  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_  
 and that death occurred, on the date stated above, at E.P.M.

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

The CAUSE OF DEATH\* was as follows:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BIRTHPLACE  
 (City or town, State or foreign country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) A. G. Gore M. D.  
5/16 1913 (Address) Marshall

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
Satisfactory Information Supplied.

\*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 \_\_\_\_\_

(ADDRESS) \_\_\_\_\_  
 Filed July 2 1913 A. C. Putnam REGISTRAR  
15 1913

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19L \_\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
Satisfactory Information Supplied.

SUPPLEMENTARY  
 Satisfactory Information Supplied.

RESERVED FOR BINDING  
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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 septichaemia," "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.)