

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 Clay
 Township _____
 or _____
 Village _____
 or _____
 City Excelsior Springs (NO. 601 N. Main)

Registration District No. 198 File No. 19226
 Primary Registration District No. 3011 Registered No. 74

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

FULL NAME Mary Jane Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Dont know 1859
(Month) (Day) (Year)

AGE About 54 yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer) Q/O

BIRTHPLACE (City or town, State or foreign country) Ky.

NAME OF FATHER Wm Jacobs

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky.

MAIDEN NAME OF MOTHER Mahila Ritter

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) S. M. Foley

(ADDRESS) Ornick Twp.

Filed June 27 1913 J. V. Bogart REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 18, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 18, 1913, to June 18, 1913, that I last saw her alive on June 18, 1913, and that death occurred, on the date stated above, at 4:30 pm.

The CAUSE OF DEATH* was as follows:
Hemiplegia left side
8217
97

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Gene Praker M. D. June 27 1913 (Address) Excelsior Springs, 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 29 yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?
 Former or usual residence Excelsior Springs Mo.

PLACE OF BURIAL OR REMOVAL Brown Hill cemetery DATE OF BURIAL June 27 1913

UNDERTAKER C. E. Carlow ADDRESS Excelsior Springs Mo.

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, 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.)

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 Clay

Township _____

or Villages _____

City Excelsior Springs

Registration District No. 198

File No. 74

Primary Registration District No. 3011

Registered No. 74

No. 601 N. Main St. _____ Ward _____

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

FULL NAME Mary Jane Cones

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Satisfactory information Supplied.

COLOR OR RACE _____

SINGLE MARRIED OR DIVORCED (Write the word)

DATE OF DEATH June 18, 1913

(Month) (Day) (Year)

DATE OF BIRTH _____

Satisfactory information Supplied.

I HEREBY CERTIFY, that I attended deceased from _____, 191____,

that I last saw h_____ alive on _____, 191____,

AGE _____

Satisfactory information Supplied.

and that death occurred, on the date stated above, at _____, m.

The CAUSE OF DEATH* was as follows:

Hemiplegia left-side

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) _____

only few hours

Contributory fall from a chair

(SECONDARY) (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) _____

(Signed) X Gustafson M. D.

June 22, 1913 (Address) Excelsior Springs

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Satisfactory information Supplied.

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Satisfactory information Supplied.

DATE OF BURIAL _____ 191____

Filed June 22, 1913

T. V. Boyard REGISTRAR

UNDERTAKER _____

ADDRESS _____

Original file, date _____ 19____

All information called for must be written on this Supplementary Certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

92261

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