

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 Perry
County St. Francois
Township St. Marys
Village _____
City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 1161 File No. 20464
Primary Registration District No. 5-881-a Registered No. 13

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

FULL NAME Doris Slinkard

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>March 14</u> , 1913 (Month) (Day) (Year)		
AGE yrs. <u>3</u> mos. <u>8</u> ds.	If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Farmington Mo.</u>		
PARENTS	NAME OF FATHER <u>Mr. Slinkard</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Perry Co. Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Grace Feuder</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Perry Co. Mo.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Cecil Feuder</u> (ADDRESS) <u>Farmington</u> Filed <u>June 22</u> , 191 <u>3</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>June 22</u> , 191 <u>3</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>June 19</u> , 191 <u>3</u> , to <u>June 22</u> , 191 <u>3</u> , that I last saw her alive on <u>June 20</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>6 p.m.</u>	
The CAUSE OF DEATH* was as follows: <u>Cholera infantum</u> <u>119A</u>	
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>B. P. Downing</u> M. D. <u>June 27</u> , 191 <u>3</u> (Address) <u>Farmington</u>	
*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 <u>Grant Mo.</u>	DATE OF BURIAL <u>June 23</u> , 191 <u>3</u>
UNDERTAKER	ADDRESS

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, 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**

PLACE OF DEATH

County

Perry
St. Marys

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

Registration District No.

1161

File No.

Township

or

Village

or

City

(NO.

St.

Ward)

Primary Registration District No.

5881-a

Registered No.

3

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

FULL NAME

Davie Slinkard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Infant

DATE OF DEATH

June 22, 1913
(Month) (Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied.

AGE

Satisfactory Information Supplied.

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)

(ADDRESS)

Filed

June 27, 1913

R. E. Crutcher
REGISTRAR

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 _____ m. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

M. D.

*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

Young, Mo.

DATE OF BURIAL

June 23, 1913

UNDERTAKER

W. J. Rose

ADDRESS

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.

SUPPLEMENTARY Satisfactory Information Supplied.

JRD

WALL

Revised United States Standard Certificate of Death

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

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