

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

PLACE OF DEATH
County Ripley
Township Jordan
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1090 File No. 3 20628
Primary Registration District No. 5987 Registered No. 3

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

FULL NAME Sarah M. Bounds

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE ☐ MARRIED ☒ WIDOWED ☒ OR DIVORCED widowed
(Write the word)

DATE OF BIRTH Nov 13, 1847
(Month) (Day) (Year)

AGE 68 yrs. 1 mos. 25 ds. If LESS than 1 day, 2 hrs. or 2 min.?

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

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

PARENTS
NAME OF FATHER William Bishop
BIRTHPLACE OF FATHER S. C.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Hill
BIRTHPLACE OF MOTHER Texas
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adeline Brooks
(ADDRESS) Grandin Mo

Filed June 10, 1913. W. G. Brooks
REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH Jan 7, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 7, 1913, to 0, 1913, that I last saw her alive on Jan 7, 1913, and that death occurred, on the date stated above, at 7 P.m.
The CAUSE OF DEATH* was as follows:

Tuberculosis old age
and decay
23A
168 (Duration) 20 yrs. 6 mos. 7 ds.

Contributory
(SECONDARY) 6 (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Adeline Brooks M. D.
Jan 7, 1913 (Address) Grandin

*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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death? at place of death
Former or usual residence Ripley Co Mo

PLACE OF BURIAL OR REMOVAL Macedonia Cemetery DATE OF BURIAL Jan 9, 1913
UNDERTAKER W. E. McKinney ADDRESS Grandin 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*, *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.)



PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should state the CAUSE OF DEATH in plain terms, so that the statement of OCCUPATION is very important.

PLACE OF DEATH

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

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

County Ripley Registration District No. 1090 File No. _____
Township Jordan Primary Registration District No. 5887 Registered No. 3
or _____
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)
FULL NAME Sarah H. Bounds (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ (Write the word)
DATE OF BIRTH _____, 191____
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 yr., 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) _____

DATE OF DEATH Jan. 7, 1913
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, and that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Without Medical aid M. D. 1-7 1913 (Address) Grandin
*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
(Informant) Satisfactory Information Supplied
(ADDRESS) _____
Filed June 10 1913 My (Proof) X
REGISTRAR

PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied
DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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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 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.)