

WHILE FILING, 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 Callaway
Township Round Prairie
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 115 File No. 22253
Primary Registration District No. 51651 Registered No. _____

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

FULL NAME Annie Louise Kemp

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED married
WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Nov 11 1856
(Month) (Day) (Year)

AGE 57 yrs. 6 mos. 17 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)

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

PARENTS
NAME OF FATHER P. F. Galvith
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
MAIDEN NAME OF MOTHER Susan E. Galvith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Cooney
(ADDRESS) Authevi mo

Filed July 28 1913 H. B. Pryor, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 27 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 27 1913, to July 27 1913, that I last saw her alive on July 27 1913, and that death occurred, on the date stated above, at 6:55 p.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Ovary
46 E
139 E (Duration) unknown ds.

Contributory Chronic enteritis (SECONDARY) (Duration) unknown mos. ds.

(Signed) H. B. Pryor M. D.
July 28 1913 (Address) Fulton Mo. R.R.

*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 57 yrs. 6 mos. 17 ds. In the State 57 yrs. 6 mos. 17 ds.
Where was disease contracted If not at place of death at place of death
Former or usual residence none

PLACE OF BURIAL OR REMOVAL Carlington Mo DATE OF BURIAL July 28 1913

UNDERTAKER G. W. Morris ADDRESS Fulton 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, 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, 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.)

County Callaway Registration District No. 115 File No. ✓
 Township Round Prairie or Village _____ Primary Registration District No. 5165 Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Annie Laura Kemp

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____ (Month) July _____ (Day) 27 _____ (Year) 1913

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds. or _____ day, _____ hrs. _____ min. If LESS than 1 day, _____ hrs. _____ min.

The CAUSE OF DEATH* was as follows: _____

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 X Seymour BIRTHPLACE OF MOTHER Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) X Wood Comer (ADDRESS) Guthrie, Mo.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____ 191____ (Address) _____

*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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____

Filed July 28 1913 X W. B. P. or M.D. REGISTRAR

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Satisfactory Information Supplied

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