

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 *Ed. Hall*
 County *Greene*
 Township _____ Registration District No. *318* File No. *22663*
 or _____
 Village _____ Primary Registration District No. *207* Registered No. *401*
 or _____
 City *Springfield* NO. *401* *Port St.* St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME *Edna Sargent*

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _____
 DATE OF BIRTH *July 20* 191*3*
 (Month) (Day) (Year)
 AGE *1* yrs. *11* mos. *14* ds. IF LESS than 1 day, 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) *Willon Springs Mo.*
 PARENTS
 NAME OF FATHER *Cyrus Sargent*
 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Missouri*
 MAIDEN NAME OF MOTHER *Ella Tibbitts*
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Missouri*
 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Cyrus Sargent*
 (ADDRESS) *401 Port St.*

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 30* 191*3*
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from *July 1*, 191*3*, to *July 31*, 191*3*, that I last saw her alive on *July 29*, 191*3*, and that death occurred, on the date stated above, at *118⁰* m.
 The CAUSE OF DEATH was as follows:
Indigestion & general weakness
119⁰ since birth
 (Duration) yrs. mos. ds.
 Contributory (SECONDARY) _____
 (Duration) yrs. mos. ds.
 (Signed) *D. N. A. Well* M. D.
July 31, 191*3* (Address) *958 W Walnut*
 *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 *Wright Park*
 DATE OF BURIAL *7-31*, 191*3*
 UNDERTAKER *W. O. K. Bump*
 ADDRESS *Wright Park Walnut*

Filed *July 31* 191*3* *Dr. C. M. Smith*
 REGISTRAR

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*, *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 surgical 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.)



PLACE OF DEATH

County Greene,

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 DEATHTownship _____
or
Village _____
or
City Springfield. (NO. _____)Registration District No. 318
Primary Registration District No. 2001File No. 22663
Registered No. 401

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

FULL NAME Edna Sargent,

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) InfantDATE OF BIRTH July 26, 1912
(Month) (Day) (Year)AGE One mos. 11 ds. IF LESS than 1 day, 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) Mellow Springs MoNAME OF FATHER Eugene Sargent

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 _____ 1913 H. W. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 30, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 1913, to July 30, 1913, that I last saw her alive on July 29, 1913, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Indigestion and general weakness since birth. EnterocolitisContributory 104 Chronic weakness
(SECONDARY) (Duration) yrs. mos. ds.
(Signed) Henry A. Well M. D.
_____, 1913 (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 _____ 1913

UNDERTAKER ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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