

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

PLACE OF DEATH
County Howard
Township _____
or
Village _____
or
City Hayette Mo (NO. _____) St. _____ Ward _____

Registration District No. 378 File No. 22749
Primary Registration District No. 4222 Registered No. 46

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

FULL NAME Lillie May Pierce

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Blk SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH March 22 1907
(Month) (Day) (Year)
AGE 6 yrs. 3 mos. 26 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Hayette Mo.

PARENTS
NAME OF FATHER Anthony Pierce
BIRTHPLACE OF FATHER (City or town, State or foreign country) Hayette Mo
MAIDEN NAME OF MOTHER Belle Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Howard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anthony Pierce
(ADDRESS) Hayette Mo

Filed July 13 1913 V. L. Pugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 6th 1913, to July 12 1913, that I last saw her alive on July 7th 1913, and that death occurred, on the date stated above, at 9:30 m.
The CAUSE OF DEATH* was as follows:

Tuberculosis
23 A
(Duration) _____ yrs. 7 mos. 10 ds.

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

(Signed) Lo P Meyer M. D.
7-20 1913 (Address) Hayette 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 _____ 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 Hayette City Cem DATE OF BURIAL July 13 1913
UNDERTAKER E. S. Shippers ADDRESS Hayette Mo

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.

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.)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Howard Registration District No. 378 File No. 11
 Township _____ or _____ Village _____ or _____ City Fayette St. _____ Ward _____
 Primary Registration District No. 4B22 Registered No. 46
 FULL NAME Lillie May Pierce

(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 F COLOR OR RACE B SINGLE MARRIED Single WIDOWED OR DIVORCED
 (Write the word)
 DATE OF BIRTH _____ (Day) _____ (Year)
 AGE _____ yrs. _____ mos. _____ ds.
 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 _____ 1913
 (Month) _____ (Day) _____ (Year)
 I HEREBY CERTIFY, that I attended deceased from _____ 1913 to _____ 1913,
 that I last saw h _____ alive on _____ 1913,
 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) C. P. Megee M. D.
7-20 1913 (Address) Fayette Mo.

SUPPLEMENTARY
 Satisfactory Information Supplied

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed July 13 1913 V. L. Bonhain
 REGISTRAR

*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. 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 _____
 Satisfactory Information Supplied

Actually supplied. AGE should be stated EXACTLY. PHYSICIANS should state if it may be properly classified. Exact statement of OCCUPATION is very important.

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