

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

PLACE OF DEATH Home  
County Linn  
Township \_\_\_\_\_ or \_\_\_\_\_  
Village \_\_\_\_\_ or \_\_\_\_\_  
City Brookfield (No. 648 S. Main St.; 4<sup>th</sup> Ward)  
Registration District No. 496 File No. 26957  
Primary Registration District No. 3025 Registered No. 70  
FULL NAME Melissa Towers [(If death occurred in a hospital or institution, give its NAME instead of street and number)]

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED OR DIVORCED <u>widow</u> (Write the word)
DATE OF BIRTH <u>July 7<sup>th</sup> 1886</u> (Month) (Day) (Year)		
AGE <u>27</u> yrs. <u>7</u> mos. <u>12</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Cleveland Ohio</u>		
PARENTS	NAME OF FATHER <u>James Anderson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scotland</u>	
	MAIDEN NAME OF MOTHER <u>Eliza Ward</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 10<sup>th</sup> 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 7<sup>th</sup> 1913, to Aug 10<sup>th</sup> 1913, that I last saw her alive on Aug 9<sup>th</sup> 1913, and that death occurred, on the date stated above, at 3<sup>45</sup> a.m.

The CAUSE OF DEATH\* was as follows:  
811 S. Appleton (Central)  
820  
(Duration) yrs. mos. 2 ds.

Contributory Familial Enteric  
(Signed) D. R. Haffner M. D.  
Aug 11<sup>th</sup> 1913 (Address) Brookfield 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 <u>Brookfield Mo Aug 12<sup>th</sup></u>	DATE OF BURIAL <u>Aug 12 1913</u>
UNDERTAKER <u>W. G. Ruck</u>	ADDRESS <u>Brookfield Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jessie Grossman  
(ADDRESS) Brookfield Mo  
Filed Aug 12<sup>th</sup> 1913 J. Hynes M.D.  
REGISTRAR

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.

ANK—THIS WRIT

# 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, peritonaum*, 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," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicæmia*," "*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.)

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

CERTIFICATE OF DEATH

PLACE OF DEATH

County Linn

Township \_\_\_\_\_

Village \_\_\_\_\_

City Brookfield (NO. 648 S. Main St.: 4th Ward)

Registration District No. 496

File No. \_\_\_\_\_

Primary Registration District No. 3025

Registered No. 70

FULL NAME Melissa Towers

[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 widow  
(Write the word)

DATE OF DEATH Aug. 10, 1913  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_  
(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.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_ sec.  
IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_ sec.

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) \_\_\_\_\_

apoplex. cerebral  
sent. ascend. paralysis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory Paralysis enter. left side of body  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

(Signed) J. B. Hynes M. D.  
Aug. 11, 1913 (Address) Brookfield

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(Informant) Satisfactory Information Supplied.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(ADDRESS) \_\_\_\_\_

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 \_\_\_\_\_

Filed Aug 12, 1913 J. B. Hynes M.D. REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 1913

UNDERTAKER Satisfactory Information Supplied. ADDRESS \_\_\_\_\_

WRITING PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD.

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SUPPLEMENTARY INFORMATION SUPPLIED.

# Revised United States Standard Certificate of Death

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

20957

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