

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 Randolph  
 Township Chariton  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 737 File No. 27470  
 Primary Registration District No. 5972 Registered No. \_\_\_\_\_

FULL NAME Mamie Fredericka Smith

(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 WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>April 8 1911</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>3</u> mos. <u>29</u> 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) <u>Nebraska</u>		
PARENTS	NAME OF FATHER <u>Roy Smith</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Macon Co, Mo</u>	
	MAIDEN NAME OF MOTHER <u>Bessie Malone Potts</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Chariton Co Mo</u>	

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH August 6, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from aug 5, 1913, to aug 6, 1913, that I last saw her alive on aug 6, 1913, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH\* was as follows:  
acute indigestion

1700 P  
11.5 P (Duration) \_\_\_ yrs. \_\_\_ mos. 1 ds.

Contributory \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) Frank L Mc Cormick M. D.  
Sept 9, 1913 (Address) Huntsville, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Smith  
(ADDRESS) Jacksonville, Mo

Filed Aug 8, 1913 Frank L Mc Cormick  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Union Chapel DATE OF BURIAL Aug 7, 1913

UNDERTAKER Andrew Minor ADDRESS Huntsville, Mo

MISSOURI STATE BOARD OF HEALTH - THIS IS A PERMANENT RECORD

# 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, 8 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, 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.)

WRITE PLAINLY, WITH UNFA

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CERTIFICATE OF DEATH

PLACE OF DEATH  
County Randolph  
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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 737 File No. \_\_\_\_\_  
Primary Registration District No. 5972 Registered No. \_\_\_\_\_

FULL NAME Mamie Fredericka Smith (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 <u>F.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> (Write the word)		DATE OF DEATH <u>Aug. 6, 1913</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Satisfactory Information Supplied.</u>				I HEREBY CERTIFY, that I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred, on the date stated above.	
AGE <u>Satisfactory Information Supplied.</u>				The CAUSE OF DEATH* was as follows: <u>Acute indigestion</u> <u>Enteritis</u>	
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)				_____ (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country)				Contributory <u>Green Granite</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER			(Signed) <u>J. J. McCannick</u> M. D. <u>Sept. 9, 1913</u> (Address) <u>Bountsville</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Satisfactory Information Supplied.</u>				Where was disease contracted If not at place of death? _____	
(ADDRESS) _____				Former or usual residence _____	
Filed <u>Aug 8, 1913</u> by <u>J. J. McCannick</u> REGISTRAR				PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
				UNDERTAKE <u>Satisfactory Information Supplied.</u>	ADDRESS _____ 191____

Original file, date AUG 1913, information called for must be written on this Supplementary Certificate.

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