

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 Clinton
 Township _____
 or _____
 Village _____
 or _____
 City Lattrop (NO. _____ St.; _____ Ward)

Registration District No. 204 File No. 29336
 Primary Registration District No. 4124 Registered No. 27

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

FULL NAME Jelina Ann Brooks

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>Jan</u> <u>3</u> , 18 <u>51</u> (Month) (Day) (Year)		
AGE <u>62</u> yrs. <u>7</u> mos. <u>29</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeping</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>" (god)</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>		
PARENTS	NAME OF FATHER <u>Carl</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill</u>	
	MAIDEN NAME OF MOTHER <u>Funk</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Do not know</u>	

4 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 1, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1913, to Sept 1, 1913, that I last saw her alive on Sept 1, 1913, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:
Cardiac atrophic dilata-
tion + interstitial nephritis
Chronic.

(Duration) 2 yrs. 936 ds.
 Contributory Atherosclerosis 97
 (SECONDARY) (Duration) 27.5 yrs. mos. ds.

(Signed) J. T. Kinsey M. D.
Sept 2 1913 (Address) Lattrop 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) J. L. Brooks
 (ADDRESS) Lattrop Mo
 Filed Sept 2, 1913 J. T. Kinsey
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Lattrop DATE OF BURIAL Sept 2, 1913
 UNDERTAKER T. G. Kupper ADDRESS Lattrop

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, 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 "Asthma," "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.)

WHILE PRINTED, WITH UNFADING INK—BEST & PERMANENT RECORD.

N. B.—Every item of information should be fully 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

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

PLACE OF DEATH
County Helinton
Township _____
or
Village _____
or
City Lathrop (NO. _____) St.: _____ Ward _____

Registration District No. 206 File No. _____
Primary Registration District No. 4124 Registered No. 27

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

FULL NAME Julia Ann Brooks

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Sept. 1, 1913
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)
Satisfactory Information Supplied

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him Satisfactory Information Supplied on _____, 191____,

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

and that death occurred, on the date stated above, at _____ m.
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)
Satisfactory Information Supplied

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

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

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

NAME OF FATHER John L. Brooks

(Signed) _____ M. D.
_____, 191____ (Address) _____

BIRTHPLACE OF FATHER Helinton, Mo.
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Agnes Finck

BIRTHPLACE OF MOTHER Helinton, Mo.
(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.

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) John L. Brooks

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

(ADDRESS) Lathrop, Mo.

UNDERTAKER Satisfactory Information Supplied

Filed Sept. 2 1913 J. T. Kinsey
REGISTRAR

Revised United States Standard Certificate of Death

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

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29336

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 **SOLENT 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.)