

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

PLACE OF DEATH

County Oregon
Township _____
or
Village _____
or
City Thayer (NO. _____ St. _____ Ward _____)

Registration District No. 632 File No. 20493
Primary Registration District No. 4382 Registered No. 92

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

FULL NAME Myrtle Agnes O'Donnell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OF RACE White MARRIED Married
OR WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH March 19 1886
(Month) (Day) (Year)

AGE 26 5 If LESS than 1 day, _____ hrs. or _____ min.?
_____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) County of Oregon

PARENTS
NAME OF FATHER W. F. Allen
BIRTHPLACE OF FATHER (City or town, State or foreign country) Oregon
MAIDEN NAME OF MOTHER Laura A. Lewis
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind. Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. F. Allen
(ADDRESS) Thayer Mo.

Filed Sept 10 1913 J. B. Bulp REGISTRAR
J. B. Bulp deputy

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 25 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 10 1913, to August 25 1913, that I last saw her alive on August 25 1913, and that death occurred, on the date stated above, at 2:00 a.m.
The CAUSE OF DEATH* was as follows:

38
Septic pneumonia
1334
Duration) 10 yrs. 10 mos. 10 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. C. Chittrell M. D.
9 191 (Address) Thayer 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 26 yrs. 5 mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence at home

PLACE OF BURIAL OR REMOVAL Thayer Mo. DATE OF BURIAL 8-27 1913

UNDERTAKER W. C. Chittrell ADDRESS Thayer 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*, *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 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 UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be spelled, and 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 Oregon
County Oregon
Township _____ or Village _____ or City Thayer (NO. _____) (St. _____ Ward _____)

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

Registration District No. 632 File No. _____
Primary Registration District No. 4382 Registered No. 22

FULL NAME Myrtle Agnes O'Donnell (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 WIDDED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>8-25-1913</u> (Month) (Day) (Year)	
DATE OF BIRTH _____ (Month) (Day) (Year)			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, at _____ m.	
AGE _____ yrs. _____ mos. _____ ds. <u>30</u> LESS than 1 day, _____ hrs. or _____ min.			The CAUSE OF DEATH* was as follows: <u>Septicemia of</u> <u>kidney and lungs</u> <u>due to malaria</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>H. B. O'Connell</u> M. D. <u>8-25-1913</u> (Address) <u>Thayer</u>	
BIRTHPLACE (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.	
PARENTS	NAME OF FATHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		Where was disease contracted if not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER _____		PLACE OF BURIAL OR REMOVAL _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		DATE OF BURIAL _____ 191____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			UNDERTAKER _____ ADDRESS _____	
Filed <u>11/10/13</u> 191 <u>3</u> <u>J. B. O'Connell</u> REGISTRAR				

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

Revised United States Standard Certificate of Death

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

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30493

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