

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty WayTownship 57Village Henrietta

City _____ (NO. _____)

Registration District No. 741File No. 30729Primary Registration District No. 4443Registered No. 17

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

FULL NAME Mary Ethel Mott

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)DATE OF DEATH September - 24 - 1913
(Month) (Day) (Year)DATE OF BIRTH Feb 22, 1892
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May - 21 - 1913, to Sept. 24 - 1913, that I last saw her alive on Sept. 24 - 1913, and that death occurred, on the date stated above, at 4 A. M.AGE 21 yrs. 7 mos. 3 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work General House work (b) General nature of industry, business, or establishment in which employed (or employer) WorshipTuberculosis Pulmonary
250 ft
(Duration) ____ mos. ____ ds.BIRTHPLACE Lafayette Co Mo
(City or town, State or foreign country) OcalaContributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds. (Signed) ✓ M. D.NAME OF FATHER Elias BarkerBIRTHPLACE OF FATHER Lafayette Co Mo
(City or town, State or foreign country)MAIDEN NAME OF MOTHER Andy SawyerBIRTHPLACE OF MOTHER Bolivar Pott Co 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) Morgan Brewer
acting
(ADDRESS) Henrietta Mo

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 9/26 1913 G W Smith
REGISTRARPLACE OF BURIAL OR REMOVAL Lower Camden Cemetery DATE OF BURIAL Sept. 25, 1913
UNDERTAKER Morgan Brewer ADDRESS Henrietta Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____
 (If d
 hospit
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 of str

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ 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) _____

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed _____ 191____
 REGISTRAR

MISSOURI STATE BOARD OF BUREAU OF VITAL STATIST CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attended
 that I last saw h _____ alive on _____, 191____, to _____
 and that death occurred, on the date stated above
The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY) _____ (Duration) _____ yrs. _____
 (Signed) _____ (Duration) _____ yrs. _____

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL
DATE _____
ADDRESS _____
UNDERTAKER _____

Statement of cause of death.—Name, first, the accepted term for the same disease. Examples: Cerebral meningitis; Epidemic typhus; Typhoid fever (the only definite synonym is "Epidemic typhus"); "Shingles" (avoid use of "herpes zoster"); "Epidemic typhus" (avoid use of "epidemic typhus").

tion whatever, write None.
 Farmer (retired, 6 yrs.) For persons who have no occu-
 tired from business, that fact may be indicated in the
 (retired, 6 yrs.) For persons who have no occu-

PLACE OF DEATH

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

MISSOURI STATE BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Ray Registration District No. 741 File No. 4
 Townshp Henriette or Village Henriette Primary Registration District No. 4443 Registered No. 13
 City _____ (NO. _____ St. _____ Ward _____) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary Ethil Mott

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE married MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

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

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Satisfactory Information Supplied.

(ADDRESS) _____
 Filed 9/26 1913 G.W. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 24, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw _____, 191____, and that death occurred, on the date stated above, at _____ The CAUSE OF DEATH* was as follows: _____

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

(Signed) G.W. Smith M. D. Sept. 24, 1913 (Address) Henriette 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 _____ DATE OF BURIAL _____
 UNDERTAKER _____ ADDRESS _____

Causes, date of death, and place of death, if different from place of death, must be stated. If death occurred in a hospital or institution, give its name and address. If death occurred in a private residence, give the name and address of the person who attended the deceased at the time of death.

Satisfactory Information Supplied.

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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name organ; "Cancer" is less definite; avoid

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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 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.)