

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.

PLACE OF DEATH
County Dent Shannon
Township Jackson Registration District No. 637 File No. 31767
or
Village Blue Grove Primary Registration District No. 6084 Registered No.
or
City (NO. St. Ward)

FULL NAME Ida Bell Vanhook

(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 <u>Married</u> (Write the word)
DATE OF BIRTH <u>June 26, 1884</u> (Month) (Day) (Year)	AGE <u>29</u> yrs. <u>2</u> mos. <u>9</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Washing</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>3-18</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Shannon Co. Mo</u>		
PARENTS	NAME OF FATHER <u>Green Hodge</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Oklahoma</u>	
	MAIDEN NAME OF MOTHER <u>Fernis Lewis</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dent Co Mo</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. Hamilton
(ADDRESS) Cedar Grove, Mo
Filed 9/8 1913. W. C. Hamilton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 3rd 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 3rd, 1913, to Sept. 6th, 1913, that I last saw her alive on Sept 3rd, 1913, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Peritonitis

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. 30 ds.
(Signed) J. A. Bault M. D.
9/5 1913 (Address) Plato, 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. 9 ds. In the 99 yrs. 2 mos. 9 ds. State
Where was disease contracted if not at place of death? at home

Former or usual residence at home

PLACE OF BURIAL OR REMOVAL V DATE OF BURIAL 9/6 1913
UNDERTAKER ADDRESS

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, peritonacum*, 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, OF 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 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.

PLACE OF DEATH

County Wentworth
 Townshp Jackson
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A CERTIFICATE UNLESS ALL ARE COMPLETED AS PRESCRIBED BY LAW

Registration District No. 037
 Primary Registration District No. 6084

File No. _____
 Registered No. _____

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

FULL NAME Ida Bell Vanhook

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 191____, to _____, 191____, 191____
(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 employed)

BIRTHPLACE
 (City or town, State or foreign country)

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 Satisfactory Information Supplied.
 (ADDRESS) _____

Filed 9/6 1913 M. C. Carroll REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 5, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I had saw him _____, 191____, and that death occurred, on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:
Peritonitis
Purpural Peritonitis
 (Duration) _____ yrs. _____ mos. 30 ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. A. Bally M. D.
9/5 1913 (Address) Rector 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 Rector DATE OF BURIAL 9/6 1913
 UNDERTAKER Cent. Laosteau ADDRESS _____

Satisfactory Information Supplied.
 SUPPLEMENTARY
 Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

1918

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