

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

33452

PLACE OF DEATH
County Madison
Township _____
or
Village LaPlato
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 532 File No. _____
Primary Registration District No. 4318 Registered No. 23

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

FULL NAME Winnie Cooley

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>March 18</u> , 18 <u>91</u> (Month) (Day) (Year)		
AGE <u>22</u> yrs. <u>6</u> mos. <u>21</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>General Housework</u>		
BIRTHPLACE (City or town, State or foreign country) <u>LaPlato Mo.</u>		
PARENTS	NAME OF FATHER <u>Jan James</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>LaPlato Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Ella Vanoy</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Jensen City Mo.</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 6, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Febry 2, 1912, to Oct 5, 1913, that I last saw her alive on Oct 4, 1913, and that death occurred, on the date stated above, at 11-30 am.

The CAUSE OF DEATH* was as follows:
Paralysis
81H
88
87B (Duration) 1 yrs. 6 mos. ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. O. Newton M. D.
Oct 8, 1913 (Address) LaPlato 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) James James
(ADDRESS) LaPlato Mo.

PLACE OF BURIAL OR REMOVAL <u>LaPlato Mo.</u>	DATE OF BURIAL <u>Oct 8</u> , 19 <u>13</u>
UNDERTAKER <u>Gooding & Sons LaPlato</u>	ADDRESS _____

Filed Oct 8, 1913, CH Bulky REGISTRAR

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*, *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*, *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 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exant 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 Macon

Township La Plata

Village La Plata

City _____

Registration District No. 532

Primary Registration District No. 4318

File No. _____

Registered No. 23

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

FULL NAME

Winnie Cooley

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M

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

AGE _____ yrs _____ mos. 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 Oct 8 1913 REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Sept 2, 1913, to Oct 5, 1913, that I last saw her alive on Oct 4, 1913,

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows: Paralysis
Landry's Paralysis with
indications of Brain Pressure.

(Duration) 2 yrs _____ mos _____ ds

Contributory Glaucoma, Blindness

(Duration) 2 yrs more

(Signed) W. O. Newton M. D.

1913 (Address) La Plata 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 _____ 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 _____, 1913

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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