

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.

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

PLACE OF DEATH

County Wagoner
Township Cedar Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward) _____

Registration District No. 893 File No. 35243
Primary Registration District No. 6195 Registered No. 17

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

FULL NAME Lidia J. White

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>American</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u>
DATE OF BIRTH <u>July 6, 1869</u> (Month) (Day) (Year)		
AGE <u>44 yrs. 2 mos. 18 ds.</u>		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) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Wagoner Co., Mo.</u>		
PARENTS	NAME OF FATHER <u>James White</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Franklin</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

2) MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH September 24, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 23, 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 10:45 a.m.
The CAUSE OF DEATH* was as follows:

Intestinal obstruction
44
17 1/2 (Duration) yrs. 10 mos. 10 ds.
Contributory uterine tumor
(SECONDARY)
(Duration) yrs. 4 mos. 4 ds.
(Signed) E. E. White M. D.
Sept. 24, 1913 (Address) Des Arc, 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 Beulah Church DATE OF BURIAL 9, 25, 1913

UNDERTAKER Johnnie Bennett ADDRESS Des Arc, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James White
(ADDRESS) Des Arc, Mo.
Filed Oct 10, 1913 O. A. Rogers REGISTRAR

N. B.—Every item of information should be carefully supplied. **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.....
 Township.....
 or Village.....
 or City.....

Registration District No. File No.
 Primary Registration District No. Registered No.

(NO.)..... St. Ward).....
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)..... (Day)..... (Year).....	IF LESS than 1 day,..... hrs. or..... min.?
AGE yrs. mos. ds.	
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)		
DATE OF DEATH	(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. The CAUSE OF DEATH* was as follows:		
Contributory (SECONDARY)..... yrs. mos. ds. (Signed)..... (Duration)..... yrs. mos. ds. M. D. 191..... (Address).....		
*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	
Filed 191.....	REGISTRAR

THIS IS A PERMANENT RECORD

N. B.—Every item of info. on this certificate is fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in appropriate place. If not stated, it should be classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Wayne
Township Cedar Creek
or
Village _____
or
City _____

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 893 File No. _____
Primary Registration District No. 6195 Registered No. 17

FULL NAME Lidia J. White (NO. _____) St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
Satisfactory information supplied

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ min. _____ sec.

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) _____

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 Oct 10 1913 REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9 — 24, 1913
(Month) (Day) (Year)

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

THE CAUSE OF DEATH* was as follows:
Intestinal Obstruction
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Contributory Uterine tumor
(SECONDARY) Non-malignant
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. C. Whiteside, M. D.
Sept 24, 1913 (Address) Des Arc, 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 _____ 1913

UNDERTAKER Intervention ADDRESS 232 1/2

SUPPLEMENTARY 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 origin; "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 *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.)