

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 Cedar
Township Madison
or
Village _____
or
City _____

Registration District No. 167
Primary Registration District No. 5233

File No. 451
Registered No. _____

FULL NAME

Mrs. Mary Ann
Laura Washburn

(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 (if write the word) <u>Widow</u>
DATE OF BIRTH <u>May</u> <u>9</u> , 1 <u>842</u> (Month) (Day) (Year)		
AGE <u>72</u> yrs. <u>7</u> mos. <u>23</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic at Mrs. King</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>		
BIRTHPLACE (City or town, State or foreign country) <u>England, London</u>		
PARENTS	NAME OF FATHER <u>Don't know</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>England</u>	
	MAIDEN NAME OF MOTHER <u>Don't know</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 2, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 11, 1913, to Jan 2, 1914, that I last saw her alive on Dec 11, 1913, and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows:
Pul. Tub.

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Chas. H. Brown M. D.
Jan 2, 1914 (Address) Four Reg. 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 2 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
Graveside, Prairie View

DATE OF BURIAL
Jan 2, 1914

UNDERTAKER
W. B. Hutchinson

ADDRESS
Four Reg. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Beckman
(ADDRESS) Four Reg. Mo.
Filed 1/10, 1914.
REGISTRAR

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, 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 *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.)

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Cedar
Township Madison
or
Village
or
City

Registration District No. 167 File No. _____

Primary Registration District No. 5233 Registered No. 1

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

FULL NAME Mary Ann Wartkau (NO. _____ St. _____ Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 2, 1914
(Month) (Day) (Year)

DATE OF BIRTH May 9, 1842
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 11, 1913, to Jan 2, 1914, that I last saw her alive on Dec 11, 1913, and that death occurred, on the date stated above, at 6:30 m.

AGE 71 yrs. 7 mos. 23 ds. If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Pul. Tho.

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) England

(Duration) 2 yrs. _____ mos. _____ ds.

PARENTS NAME OF FATHER Sam Brown BIRTHPLACE OF FATHER England MAIDEN NAME OF MOTHER Sam Brown BIRTHPLACE OF MOTHER Sam Brown

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) Chas. H. Brown M. D. Jan 2, 1914 (Address) Fair Play Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Joe Rickman ADDRESS Bear Creek 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 2 yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted If not at place of death? Former or usual residence _____

Filled 110, 1914 J. J. [Signature] REGISTRAR

PLACE OF BURIAL OR REMOVAL Lucky Spring Cem. DATE OF BURIAL Jan 2, 1914 UNDERTAKER A. Rickman & Son ADDRESS Bear Creek Mo.

JAN - 1914

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state. N. B. - Every item of information should be carefully supplied. AGE should be stated. OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

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