

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

613

PLACE OF DEATH
County Dallas
Township Jasper
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 244 File No. _____
Primary Registration District No. 5338 Registered No. _____

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

FULL NAME Cassada Adams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE white SINGLE single MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH January 14, 1914
(Month) (Day) (Year)

DATE OF BIRTH February 14, 1883
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 10, 1914, to Jan 14, 1914, that I last saw her alive on Jan 14, 1914, and that death occurred, on the date stated above, at her home.

AGE 20 yrs. 11 mos. 0 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Appendicitis

OCCUPATION (a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)

121 B
129 (Duration) ___ yrs. ___ mos. 7 ds.

BIRTHPLACE (City or town, State or foreign country) Dallas Co. Mo.

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

NAME OF FATHER Gas Adams

(Signed) J. Phillips M. D. (Address) Lead

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dallas Co. Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER Addie Adams Stone

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dallas Co. Mo.

Where was disease contracted If not at place of death? _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jessie Adams

Former or usual residence _____

(ADDRESS) Long Lane Mo.

PLACE OF BURIAL OR REMOVAL Lead Ridge DATE OF BURIAL Jan 15, 1914

Filed Jan 18, 1914 REGISTRAR

UNDERTAKER Lovanathan Buffalo Mo. ADDRESS _____

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 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.)

PLACE OF DEATH

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

County

Dallas

Township

Gasper

Registration District No.

244

File No.

Village

Primary Registration District No.

5338

Registered No.

City (NO. St. Ward)

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

FULL NAME

Consuela Adams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

F

COLOR OR RACE

w

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

S

DATE OF DEATH

Jan 14 1914

DATE OF BIRTH

(Month) (Day) (Year)

AGE

... yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

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 *4 P.* m.

The CAUSE OF DEATH* was as follows:

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)

(ADDRESS)

Filed

Jan 18 4 11/15 A.P. Vandy
REGISTRAR

Contributory

(SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

(Duration) ... yrs. ... mos. ... ds.

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

Original file, date

JAN 1914

19... All information called for must be written on this Supplementary Certificate.

Satisfactory Information supplied.

Satisfactory Information supplied.

Satisfactory Information supplied.

REPRODUCTION OF THIS CARD IS PROHIBITED WITHOUT PERMISSION OF THE BOARD OF HEALTH. Exact statement of 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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