

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		MISSOURI STATE BOARD OF HEALTH	
County <u>Johnson Co</u>		BUREAU OF VITAL STATISTICS	
Township _____		Registration District No. <u>431</u>	File No. <u>1545</u>
or Village _____		Primary Registration District No. <u>3023</u>	Registered No. <u>3</u>
or City <u>Warrensburg</u> (NO <u>Mo E Gay street</u> St. _____ Ward _____)		(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME <u>Mrs Lena Spiess</u>			

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u>	DATE OF DEATH <u>Jan 3</u> , 191 <u>4</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Unknown</u> (X), 18 <u>36</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Dec 28</u> , 191 <u>3</u> , to <u>Jan 3</u> , 191 <u>4</u> , that I last saw her alive on <u>Jan 3</u> , 191 <u>4</u> , and that death occurred, on the date stated above, at <u>7:30</u> m.		
AGE <u>78</u> yrs. ____ mos. ____ ds.		IF LESS than 1 day, ____ hrs. or ____ min.?	The CAUSE OF DEATH* was as follows: <u>Pneumonia</u> <u>108</u> (Duration) ____ yrs. ____ mos. <u>6</u> ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Texas</u>			(Signed) <u>Wm E Johnson</u> M. D. <u>Jan 7</u> , 191 <u>4</u> (Address) <u>Warrensburg</u>		
PARENTS	NAME OF FATHER <u>Unknown</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	*State the Disease Cause, Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER <u>Unknown</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.		
	THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Lena Spiess</u>			Where was disease contracted if not at place of death? _____	
	(ADDRESS) <u>Warrensburg Mo</u>			Former or usual residence _____	
Filed <u>Jan 8</u> , 191 <u>4</u> <u>S. Calrock</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>City Cemetery</u>	DATE OF BURIAL <u>Jan 5</u> , 191 <u>4</u>	
			UNDERTAKER <u>O. A. Danner</u>	ADDRESS <u>Warrensburg</u> <u>2000</u>	

# 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, peritonaeum*, 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, 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.

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PLACE OF DEATH Johnson  
 County Johnson  
 Township \_\_\_\_\_ Registration District No. 431 File No. \_\_\_\_\_  
 Village \_\_\_\_\_ Primary Registration District No. 3023 Registered No. 3  
 or \_\_\_\_\_  
 City Wamashung (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 FULL NAME Leola Spiess

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE  MARRIED  WIDOWED  OR DIVORCED  (Write the word) W  
 DATE OF BIRTH \_\_\_\_\_ (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 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) \_\_\_\_\_

DATE OF DEATH Jan 3, 1914  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1914, to \_\_\_\_\_, 1914, that I last saw him alive on \_\_\_\_\_, 1914, and that death occurred, on the date stated above, at 7:30 m.  
 The CAUSE OF DEATH\* was as follows:  
Pneumonia Lobare  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.  
 Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Wm. E. Johnson, M. D.  
Jan 7, 1914 (Address) Wamashung

Satisfactory Information Supplied. SUPPLEMENTARY INFORMATION SUPPLIED.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_  
 Filled 1/8 1914 W. C. Cadcock REGISTRAR

\*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 Salina 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 \_\_\_\_\_ 1914  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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5/15/11