

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

4146

PLACE OF DEATH  
County Cape Girardeau  
Township Liberty  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 130 File No. \_\_\_\_\_  
Primary Registration District No. 5781 Registered No. 3

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

FULL NAME Willie Jane Welker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED married  
WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH Feb. 8, 1914  
(Month) (Day) (Year)

DATE OF BIRTH unknown, 19??  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 3, 1914, to Feb. 8, 1914, that I last saw her alive on Feb. 8, 1914,

AGE 40 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

and that death occurred, on the date stated above, at 11 1/2 m.

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

The CAUSE OF DEATH\* was as follows:  
Pneumonia  
10<sup>0</sup>  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

BIRTHPLACE (City or town, State or foreign country) Cape Girardeau Co.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER David Hahn

(Signed) J. M. Purvisley M. D. \_\_\_\_\_ 1914 (Address) \_\_\_\_\_

BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown

MAIDEN NAME OF MOTHER Carrie Newwanger

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cape Girardeau Co.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. J. Hahn

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 \_\_\_\_\_

(ADDRESS) Millerville Mo.

PLACE OF BURIAL OR REMOVAL Barber Cemetery DATE OF BURIAL Feb. 9, 1914

Filed 2/10, 1914

UNDERTAKER W. H. Hinton ADDRESS Allenville Mo.

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**PLACE OF DEATH**

County.....

Township.....

or

Village.....

or

City.....

Registration District No. ....

Primary Registration District No. ....

File No. ....

Registered No. ....

(NO. ....

St.; .....

Ward) .....

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX.....

COLOR OR RACE.....

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(If write the word)

DATE OF BIRTH.....

(Month)..... (Day)..... (Year).....

AGE.....

IF LESS than  
1 day,.....hrs.  
or.....min.?

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

OCCUPATION.....

(a) Trade, profession, or business, or establishment in which employed (or employer) .....

(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....., 191....., REGISTRAR.....

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

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH....., 191..... (Month)....., 191..... (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:

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

**Contributory**

(SECONDARY)

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

(Signed).....

191..... (Address)..... M. D. ....

\*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....., 191.....

UNDERTAKER.....

ADDRESS.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information on this certificate should be written in plain, legible characters. If the information is not available, it should be so stated. If the information is not available, it should be so stated. If the information is not available, it should be so stated.

PLACE OF DEATH

County Cape Girardeau  
Township Liberty  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

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

Registration District No. 130 File No. \_\_\_\_\_  
Primary Registration District No. 5781 Registered No. 31

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

FULL NAME Lillie Jane Wecker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH 2/8, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 110 m.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_ sec.

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) \_\_\_\_\_

Pneumonia  
Labar. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) J. M. P. M. D. 1914 (Address) Whitewater, Mo.

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) \_\_\_\_\_

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ (ADDRESS) \_\_\_\_\_

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 \_\_\_\_\_

Filed 7/10 1914 at A. M. Murphy REGISTRAR

PLACE OF BURIAL OR REMOVAL Barco County DATE OF BURIAL \_\_\_\_\_ 1914  
UNDERTAKER A. H. Thibodeau ADDRESS \_\_\_\_\_

# 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*, *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 "Asthemia," "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.)

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