

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

4305

PLACE OF DEATH
County Cole
Township Jefferson
or
Village
or
City Jefferson (NO. 1117 E. Elm St. Ward)

Registration District No. 213 File No.
Primary Registration District No. 3014 Registered No. 339

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

FULL NAME Martha Price

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Col. SINGLE widowed MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Feb 19 1856
(Month) (Day) (Year)
AGE about 58 yrs
IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Boone Co. Mo. 1876

PARENTS
NAME OF FATHER Bob. Ridgeway
BIRTHPLACE OF FATHER (City or town, State or foreign country) 2
MAIDEN NAME OF MOTHER Hanna Ridgeway
BIRTHPLACE OF MOTHER (City or town, State or foreign country) 2

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis Price
(ADDRESS) Jefferson City, Mo
Filed Feb. 21 1914 W. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 19 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Feb 9, 1914, to Feb 9, 1914, that I last saw her alive on Feb 9, 1914, and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ___ yrs. ___ mos. ___ ds.
Contributory paralysis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) O. E. Gross M. D.
Feb 21 1914 (Address) 302 3/4 E. High St.

*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 City Cemetery DATE OF BURIAL 2/21 1914
UNDERTAKER Walter H. Jones ADDRESS J. C. Mo.

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, 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 "*Assthenia,*" "*Anaemia*" (merely symptomatic), "*Atrophv.*" "*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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Cole

Township _____

Registration District No. 213

File No. _____

or Village _____

Primary Registration District No. 3014

Registered No. 339

or City Jefferson City

(NO. 1117 E Elm St.:

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

FULL NAME Martha Price

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF RACE B SINGLE MARRIED WIDOWED OR DIVORCED w
(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 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) _____

Filed 7/21 1914 H. A. Bayford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7/19 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory information supplied _____, 1914, that I last saw h. _____ alive on _____, 1914, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Pneumonia Broncho
X 91 X
(Duration) _____ yrs. _____ mos. 2 ds.

Contributory Paralysis (Attending Physician) _____
(Duration) _____ yrs. 9 mos. _____ ds.
(Signed) O. E. Amos M. D.
7/21 1914 (Address) 302 E. High St.

*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 _____ 1914

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied

SUPPLEMENTARY

Certificate

Revised United States Standard Certificate of Death

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

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