

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

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

5214

PLACE OF DEATH
County Frank 1029
Township West Shiloh 5602 Registration District No. 1009 File No. _____
or _____
Village _____ Primary Registration District No. 5602 Registered No. (3)
or _____
City _____ (NO. _____) St. _____ Ward _____
FULL NAME Sarah Cole [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH Feb 11 1846
(Month) (Day) (Year)
AGE 68 yrs. 1 mos. 1 ds. 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) Mkt of Knoxville Tenn

BIRTHPLACE
(City or town, State or foreign country) Tenn

PARENTS
NAME OF FATHER J. W. Jones
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
MAIDEN NAME OF MOTHER Sarah M. Lee
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Jones

(ADDRESS) Hurdland mo

Filed Feb 11 1914 D J Horvostan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 11 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1 1914, to Feb 11 1914, that I last saw her alive on Feb 1 1914, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis
878
(Duration) 3 yrs. - mos. - ds.

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

(Signed) D J Horvostan M. D.
Feb 1914 (Address) Hurdland

*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 New Knoxville Mo DATE OF BURIAL Feb 12 1914

UNDERTAKER Frank G. Christie ADDRESS Jalata Mo

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.)

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

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

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

PLACE OF DEATH Trux
 County Shelton
 Township Shelton Registration District No. 1029 File No. _____
 or _____
 Village _____ Primary Registration District No. 5602 Registered No. 31
 or _____
 City _____ (No. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Col

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH _____, 1 _____, 1914
 (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 4/11, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914,
 Satisfactory Information Supplied, _____, 1914,
 that I last saw h. alive on _____, 1914,
 and that death occurred, on the date stated above, at 20 m.
 The CAUSE OF DEATH* was as follows:
Paralysis agitans

(Duration) 3 yrs. 4 mos. 4 ds.

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

(Signed) D. G. Horner M. D.
2 1914 (Address) Hurdland

*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 _____

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

Filed 4/11 1914 D. G. Horner REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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