

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

5410

PLACE OF DEATH
County Mason
Township _____
or _____
Village _____
or _____
City Hannibal (NO. 416 Munger St. 5 Ward)

Registration District No. 547 File No. _____
Primary Registration District No. 3029 Registered No. 41

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

FULL NAME Susan Heber

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Sept 14, 1884
(Month) (Day) (Year)

AGE 65 yrs. 4 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Jacob Shunkle
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.
MAIDEN NAME OF MOTHER Margaret Shunkle
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. S. Graper
(ADDRESS) Hannibal
Filed Feb 11, 1914. M. J. Young REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 10, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 4, 1914, to Feb. 10, 1914, that I last saw her alive on Feb. 9, 1914, and that death occurred, on the date stated above, at 7:40 p. m.

The CAUSE OF DEATH* was as follows:
Senility
1060
112
162 (Duration) ___ yrs. ___ mos. ___ ds.
Contributory Bronchitis, Catarrh (SECONDARY) (Duration) 18 yrs. ___ mos. ___ ds.

(Signed) H. Schmidt M. D.
Feb 11, 1914 (Address) Hannibal, Mo

*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 Mt. Olivet Cemetery DATE OF BURIAL Feb 12, 1914
UNDERTAKER Leivers and Co ADDRESS Hannibal

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.)

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

PLACE OF DEATH
 County Marion
 Township _____
 or
 Village _____
 or
 City Hubbal (NO. _____) St.: _____ Ward _____

Registration District No. 541 File No. _____
 Primary Registration District No. 3029 Registered No. 41A

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

FULL NAME Susan Webber

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 10, 1914
(Month) (Day) (Year)

DATE OF BIRTH 11/10/1880
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day, _____ hrs. or _____ min.

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) _____

Senility (Age)

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

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

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) _____

(Signed) R. Schmidt M. D.
2-11-1914 (Address) Hubbal Mo

*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 X 1914 REGISTRAR X

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.
 Satisfactory Information Supplied.
 Satisfactory Information Supplied.

Satisfactory Information Supplied.

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