

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

PLACE OF DEATH

County Saline
Township Liberty
or Village Wheatland
or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 801 File No. 3-7016
Primary Registration District No. 5883 Registered No. _____
6045

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

FULL NAME Elizabeth Yankee

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April 16, 1896
(Month) (Day) (Year)

AGE 67 yrs. 9 mos. 29 ds.
If LESS than 1 day, M. hrs. or 5 min.?

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

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

PARENTS
NAME OF FATHER Benjamin Ramsdell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Louisville Ky.
MOTHER'S NAME Elizabeth Higgins
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bedalia Mo.

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant C. W. Kennedy
(ADDRESS) Sweet Springs Mo.
Feb 16, 1914 J. H. Jackson REGISTRAR
Dr. J. H. Smith

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 15, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1st 1913, to Feb 15, 1914, that I last saw her alive on Feb 15, 1914, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis - Chronic
1914

(Duration) 3 yrs. 5 mos. 10 ds.
Contributory heart failure
(SECONDARY) (Duration) 7 yrs. 5 mos. 10 ds.
(Signed) J. H. Smith M. D.
Feb 16, 1914 (Address) Wheatland 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 9 yrs. 2 mos. 15 ds. In the State 9 yrs. 2 mos. 15 ds.
Where was disease contracted if not at place of death? Mo. Pleasant Grove Mo.
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Linsdale, Missouri DATE OF BURIAL 2/17, 1914
UNDERTAKER G. C. Carter ADDRESS Sweet Springs Mo.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty DaloueTownship _____
or _____

Registration District No. _____

File No. _____

Village _____
or _____

Primary Registration District No. _____

Registered No. _____

City _____

(NO. _____)

FULL NAME Eлизабет Яаркев

St.: _____

Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) <u>1</u> (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) _____

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 _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Feb (Month) _____15 (Day) _____1914 (Year)I HEREBY CERTIFY, that I attended deceased from Dec 1st, 1914, to Feb 15, 1914, that I last saw her alive on Feb 15, 1914, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Thromboclebrachitis

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 _____

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REGISTRAR _____

DATE OF DEATH

Feb (Month) _____15 (Day) _____1914 (Year)I HEREBY CERTIFY, that I attended deceased from Dec 1st, 1914, to Feb 15, 1914, that I last saw her alive on Feb 15, 1914, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Thromboclebrachitis

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 _____

CONTRIBUTORY

(SECONDARY)

CONTRIBUTORY

(SECONDARY)

(Signed) _____

191 _____ (Address) _____

* 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. 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 _____

UNDERTAKER

ADDRESS _____

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

PLACE OF DEATH

County Saline

Township Liberty

or Village _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 801

File No. _____

Primary Registration District No. 6045

Registered No. _____

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

FULL NAME Elizabeth Yankee

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED widow WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Feb 15, 1914
(Month) (Day) (Year)

DATE OF BIRTH April 16, 1846
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1913, to Feb 15, 1914, that I last saw her alive on Feb 15, 1914, and that death occurred, on the date stated above, at 4 P. m.

AGE 67 yrs. 9 mos. 29 da. IF LESS than 1 day, ___ hrs. or ___ min.

The CAUSE OF DEATH* was as follows:

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

Bronchitis Chronic

BIRTHPLACE (City or town, State or foreign country) Pettus Mo

(Duration) 3 yrs. 5 mos. 10 ds.

NAME OF FATHER B. Russell

Contributory Heart failure
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) J. Smith M. D.
7/16, 1914 (Address) Houstronia Mo

MAIDEN NAME OF MOTHER E. Higgins

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Inherent) E. W. Kennedy

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

RESIDENCE (ADDRESS) Sweet Spgs Mo

Where was disease contracted if not at place of death? _____

7/16, 1914 J. D. Jackson REGISTRAR

Former or usual residence. _____

PLACE OF BURIAL OR REMOVAL Lincoln Mission DATE OF BURIAL 7/17, 1914

UNDERTAKER N. C. Carter ADDRESS Sweet Spgs Mo

WHILE FILLING IN, WITH UNFADING INK - THIS IS 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.

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

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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.)