

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

7342

PLACE OF DEATH
County Barry
Township Mineral Spgs
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 29 File No. _____
Primary Registration District No. 5039 Registered No. 44

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

FULL NAME Bertha Bauerher

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH March 23, 1914
(Month) (Day) (Year)

DATE OF BIRTH June 5th, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 16, 1914, to Mar 23, 1914, that I last saw her alive on Mar 22, 1914, and that death occurred, on the date stated above, at 12 m.

AGE 2 yrs. 9 mos. 18 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
662
197A Pneumonia
(Duration) _____ yrs. _____ mos. 4 ds.

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

Contributory Cretinism (SECONDARY) (Duration) 2 yrs. _____ mos. _____ ds.
(Signed) S. W. Chasche M. D.
Mar 23, 1914 (Address) Cassville Mo

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

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

PARENTS NAME OF FATHER J. D. Dousher BIRTHPLACE OF FATHER (City or town, State or foreign country) Kansas
MAIDEN NAME OF MOTHER Lena Nilson BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ark

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) J. W. Nilson (ADDRESS) Cassville Mo

PLACE OF BURIAL OR REMOVAL Bowsher Cem DATE OF BURIAL 3/24, 1914
UNDERTAKER T. J. Horne ADDRESS Cassville Mo

Filed 3/28 1914 REGISTRAR T. J. Horne

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*, *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*, *peritonæum*, 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 "Asthénia," "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

Barry
Mineral Spg.

Township

or Village

or City

Registration District No.

Primary Registration District No.

File No.

Registered No.

29

5039

44

(NO.)

St.:

Ward

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

FULL NAME

Betha Bowsher

PERSONAL AND STATISTICAL PARTICULARS

SEX *F* COLOR OR RACE *W*

SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)

DATE OF BIRTH *Satisfactory Information Supplied.*
(Month) (Day) (Year)

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

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed 191

J. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *3-23-1914*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ 191____,

and that death occurred, on the date stated above, _____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Bronch Pneumonia
(Duration) *9* yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. *9*
(Signed) *Sevelhaender* M.D.
3-23-1914 (Address) *Cassville 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 DATE OF BURIAL _____ 191____

UNDERTAKER ADDRESS *Supplied.*

SUPPLEMENTARY Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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