

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

PLACE OF DEATH

County Madison Registration District No. 638 File No. 9204
 Township Marion or Village _____ Primary Registration District No. 8720 Registered No. 7
 City _____ (NO. _____ St.; _____ Ward)

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

FULL NAME

Eda Trimble

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>Nov 20th, 1887</u> (Month) (Day) (Year)		
AGE <u>28</u> yrs. <u>3</u> mos. <u>15</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife 1498th</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeping</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Madison Mo</u>		
PARENTS	NAME OF FATHER <u>Jones</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Madison</u>	
	MAIDEN NAME OF MOTHER <u>Martha Thompson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Madison</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 27th, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 6th, 1914, to Nov 17th, 1914, that I last saw her alive on Nov 7th, 1914, and that death occurred, on the date stated above, at 1498th.
 The CAUSE OF DEATH* was as follows:

Overfed child resulting from venereal and infectious milt delivery of child.
 (Duration) ___ yrs. ___ mos. 2 1/2 ds.

Contributory C. B. White's Spine
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) Dr. J. P. Gibson M. D.
Nov 27th, 1914 (Address) Exp. 1111

*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) J. Frank Trimble

(ADDRESS) Jacksonville Mo

Filed Nov 27, 1914. J. P. Gibson
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Jacksonville Mo DATE OF BURIAL Nov 27, 1914

UNDERTAKER J. E. Brown ADDRESS Jacksonville 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*, *Sar-*

coma, 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.)



PLACE OF DEATH

County

*Macou*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.

Township

or

Village

or

City

(NO.

St.

Ward)

Registration District No.

535

File No.

Primary Registration District No.

5720

Registered No.

7

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

FULL NAME

Ada Trumble

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

*w*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*m*

DATE OF BIRTH

(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)

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

Jan 10 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May 7

1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

, 191

, 191

that I last saw h. alive on

, 191

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

, 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.

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

Filed

Jan 10 1914

REGISTRAR

MAR 10 1914

Original file, date

19

All information called for must be written on this Supplementary Certificate.

N. - 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.

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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92026
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