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 Greene

Township ..... Registration District No. 318 File No. 12259

or Village ..... Primary Registration District No. 2001 Registered No. 206

or City Springfield No. 667 Madison St.; ..... Ward)

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

FULL NAME Martha Jane Barrus

PERSONAL AND STATISTICAL PARTICULARS

SEX Fem | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH Aug. (Month) 28 (Day), 1840 (Year)

AGE 74 yrs. ..... mos. ..... 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) Ohio

PARENTS

NAME OF FATHER James Maxwell

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

MAIDEN NAME OF MOTHER Plummer

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) U. W. Burris

(ADDRESS) Joplin, Mo

Filed April 1, 1914. Dr C W Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

DATE OF DEATH March (Month) 30 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 14, 1909, to March 30, 1914, that I last saw her alive on March 30, 1914, and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

97A

93C

75B (Duration) 10 yrs. ..... mos. ..... ds.

80

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

(Signed) A. L. Anderson M. D.

March 30, 1914 (Address) 318 College

*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 Green Lawn | DATE OF BURIAL 4-1, 1914

UNDERTAKER Payson Und Co | ADDRESS 410 South

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, peritonaeum*, 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 *septichaemia*," "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.)

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

County: Greene

Township: _____ Registration District No. 318 File No. _____

or Village: _____ Primary Registration District No. 3001 Registered No. 306

or City: Springfield (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Martha Jane Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word): W

DATE OF BIRTH: _____ (Month) _____ (Day) 1 (Year)

Satisfactory Information Supplied.

AGE: _____ 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) _____

Satisfactory Information Supplied.

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) _____

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Satisfactory Information Supplied.

Filed Apl 1, 191 4 Edwin H. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch 30, 191 4 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at 8 P m.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:
Cerebral Hem. Lt.
Angiovascular disease - also
Chronic Myocarditis
Don't Know.

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

Contributory (SECONDARY) _____

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

(Signed) A. L. Anderson M. D.

Mch 30, 191 4 (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 _____

Satisfactory Information Supplied.

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191__

UNDERTAKER _____ ADDRESS _____

Original file, date Apl 1, 1914, 19__ All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Please print further, 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]

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12259