

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

13339

PLACE OF DEATH

County Missouri  
Township Liberty  
or  
Village Galt Mo  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 327  
Primary Registration District No. 5453

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

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

FULL NAME

Mary A. Elwood

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widowed  
(Write the word)

DATE OF BIRTH

April 27, 1837  
(Month) (Day) (Year)

AGE

56 yrs. 10 mos. 10 ds.

If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Retired. voc  
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE

(City or town, State or foreign country) Canada

NAME OF FATHER

Geo. Jewett

BIRTHPLACE OF FATHER

(City or town, State or foreign country) London Eng

MAIDEN NAME OF MOTHER

Mary A. Crossin

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Jewett  
Galt Mo  
(ADDRESS)

Filed April 4, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar. 10, 1914  
(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 \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Dr. K. Shinger waited on this Patient until his death had. No Dr for 2 yrs. to wait on him to (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 Usual

PLACE OF BURIAL OR REMOVAL

1007. Am. Galt Mo

DATE OF BURIAL

3-12, 1914

UNDERTAKER

RK Payne

ADDRESS

Galt Mo

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.

RESERVED FOR BINDING

# 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*, *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

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

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

County Gentry  
Township Liberty  
or  
Village  
or  
City

Registration District No. 327 File No.  
Primary Registration District No. 5453 Registered No. 3  
City (NO. St. Ward)

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

FULL NAME Mary A. Elwood

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W  
(Write the word)  
DATE OF BIRTH  
(Month) (Day) (Year)  
AGE  
If LESS than 1 day, hrs. or mins.  
yrs. ds.

DATE OF DEATH 3/10, 1914  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191, to \_\_\_\_\_, 191,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
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)

Strump written on the Stump Hotel his death at W. St. for 2 yo  
Duration) yrs. mos. ds.

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)

Contributory Cause Unknown  
(SECONDARY) (Duration) yrs. mos. ds.  
(Signed) A. E. Brewer M. D.  
191 (Address) Holt Ind

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)

\*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 mos. ds. In the State yrs. mos. ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

(ADDRESS)  
Filed 4/4 1914 A. E. Brewer REGISTRAR

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
UNDERTAKER ADDRESS  
P. K. Payne

MARGIN HERE  
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.

Satisfactory information Supplied.  
SUPPLEMENTARY  
Satisfactory information Supplied.  
Satisfactory information Supplied.

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