

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 Pike
Township Perry
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 688
Primary Registration District No. 5916

File No. 13486
Registered No. 9

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

FULL NAME Anna Hood

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE white SINGLE MARRIED widowed WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 2nd, 1853
(Month) (Day) (Year)

AGE 81 yrs. 26 mos. 22 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) Mo.

PARENTS
NAME OF FATHER Nathaniel Porter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.
MAIDEN NAME OF MOTHER Lucinda Bailey
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virg.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE—

(Informant) Geo Porter
(ADDRESS) Frankford Mo
Filed Apr 24 1914 1914
J. J. Kennedy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Apr 22, 1914, to Apr 23, 1914, that I last saw u alive on Apr 22, 1914, and that death occurred, on the date stated above, at 6:25 a.m.

The CAUSE OF DEATH* was as follows:
apoplexy
151
1914
(Duration) ___ yrs. ___ mos. ___ ds. ✓

Contributory nephritis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. J. Kennedy M. D.
4/24, 1914 (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 Frankford Mo DATE OF BURIAL Apr 24, 1914
UNDERTAKER L. H. Family ADDRESS Frankford 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*, *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

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.)

Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY.

PLACE OF DEATH

County Pike

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

688

Township _____

Registration District No. _____

File No. _____

Village _____

Primary Registration District No. 5916

Registered No. 9

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Anna Ford

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W (If fill the word)

MEDICAL CERTIFICATE OF DEATH

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

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I had saw h _____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

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

OCCUPATION (a) Trade, profession, or particular kind of work _____

Apoplexy
Chronic Nephritis
Contributory (SECONDARY) _____

(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 4/24 1914 J. H. Kennedy REGISTRAR

(Duration) _____ yrs. _____ mos. _____ ds. (Signed) J. H. Kennedy M. D. 432 W. Franklin

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECEIVING 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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

APR 24 1914

Revised United States Standard Certificate of Death

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

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