

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

PLACE OF DEATH

County Berrie Stoddard
Township Berrie Liberty
or
Village
or
City Berrie (NO. _____ St. _____ Ward _____)

Registration District No. 836 File No. 14967
Primary Registration District No. 6098a Registered No. 30

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

FULL NAME Lue Cooper

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Jan 19, 1914
(Month) (Day) (Year)

AGE 16 yrs. 2 mos. 16 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE
City or town, State or foreign country Stoddard Co

NAME OF FATHER St. Cooper

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Stoddard Co

MAIDEN NAME OF MOTHER Litheloh Miggins

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Old Creek Bluff

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Sign) J.H. Cooper
(ADDRESS) Berrie, Mo

Signature H. J. Callen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 5, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 8, 1914, to April 5, 1914, that I last saw her alive on March 26, 1914, and that death occurred, on the date stated above, at 59 m. The CAUSE OF DEATH' was as follows:

Burned accidentally
181
(Duration) ____ yrs. ____ mos. 28 ds.

Contributory (SECONDARY)
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) George Dabon M. D.
4-9, 1914 (Address) Walden, 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 Stevens Chapel DATE OF BURIAL April 6, 1914

UNDERTAKER M. L. Hadley ADDRESS Berrie, Mo.

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, 8 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH Goddard
 County Liberty Registration District No. 836 File No. _____
 Township _____ Primary Registration District No. 6098a Registered No. _____
 Village _____ City _____ NO. _____ St. _____ Ward _____

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

FULL NAME Luce Cooper

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX 7 COLOR OR RACE W SINGLE S
 MARRIED _____ WIDOWED _____ OR DIVORCED _____
 (If write the word)
 DATE OF BIRTH factory information supplied
 (Month) _____ (Day) _____ (Year) _____
 AGE factory information supplied
 yrs. _____ mos. _____ ds. If LESS than 1 day _____ hrs. _____ min.

DATE OF DEATH Apr. 5 1914
 (Month) _____ (Day) _____ (Year) _____
 I HEREBY CERTIFY, that I attended deceased from _____, 191____ to _____, 191____
 that I last saw _____, 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) _____
 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) _____

Burned accidental
Caught dress from open fire under net
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____
 (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Geo. W. [Signature] M. D.
4/4 1914 (Address) Walden Mrs.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed Wright H. Call 1914
 REGISTRAR

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 INFORMATION SUPPLIED
 Satisfactory Information supplied

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.

Revised United States Standard Certificate of Death

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

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