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

PLACE OF DEATH

County: Webster

Township: Ozark
or
Village:
or
City: (NO. ____, ____ St.; ____ Ward)

Registration District No. 896 — File No. 15124

Primary Registration District No. 6198 — Registered No. 19

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

FULL NAME Flora Elizabeth Alexander

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: October (Month) 17 (Day), 1913 (Year)

AGE: ____ yrs. 5 mos. 18 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): Webster Co Mo

PARENTS
NAME OF FATHER: J. A. Alexander
BIRTHPLACE OF FATHER (City or town, State or foreign country): Hobson Co Mo
MAIDEN NAME OF MOTHER: Tilia King
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Hobson Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Marshfield Mo

(ADDRESS): Rufus Alexander

Filed 4/5/14, 191__ — J R Bruce, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr. (Month) 4 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 4, 1914, to Apr 3, 1914, that I last saw her alive on Apr 3, 1914, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia with Pleural Effusion
110B
107A

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): none

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) M. Thiffile M. D.

Apr 4, 1914 (Address) Marshfield 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: Black Oak — DATE OF BURIAL: Apr. 5, 1914

UNDERTAKER: H T McMahan — ADDRESS: Marshfield Mo

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]

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 Webster

Township Ozark

or

Village

or

City (NO. St.: Ward)

Registration District No. 896 File No.

Primary Registration District No. 6198 Registered No. 19

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

FULL NAME Flora E Alexander

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*) S

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

AGE yrs. 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)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed 4/5 1914 J R Bruce REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 4 (Month) (Day) 1914 (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 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia with Plural Effusion Broncho

(Duration) yrs. mos. 20 ds.

Contributory (SECONDARY) Measles

(Duration) yrs. mos. 7 ds.

(Signed) M Highfill M.D.

4/4 1914 (Address) Marshfield 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

DATE OF BURIAL 191

UNDERTAKER

ADDRESS

Satisfactory Information Supplied.

SUPPLEMENTARY

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Original file, date APR — 1914 19 All information called for must be written on this Supplementary Certificate.

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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