

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

PLACE OF DEATH
County Christian
Township Linden
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 185 File No. 15599
Primary Registration District No. 5259 Registered No. 13

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

FULL NAME Henryetta Horn

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>Nov 26, 1873</u> (Month) (Day) (Year)		
AGE <u>40</u> yrs. <u>4</u> mos. <u>4</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>House work</u>		
BIRTHPLACE (City or town, State or foreign country) <u>N. Carolina</u>		
PARENTS	NAME OF FATHER <u>Calvin Greene</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>N. C.</u>	
	MAIDEN NAME OF MOTHER <u>Carrie Farthing</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>N. C.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Horn
(ADDRESS) Rogersville Mo

Filed May 25, 1914, R. R. Farthing
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar. 30, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 23, 1914, to Mar 30, 1914, that I last saw her alive on Mar 30, 1914, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia
149 B
125 P
36 (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) R. R. Farthing M. D.
Mar 30, 1914 (Address) Spanta 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 Pembina Cem DATE OF BURIAL Mar 31, 1914

UNDERTAKER H. V. Reid ADDRESS Osark Mo.

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]

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.)

PLACE OF DEATH

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

County Christian

Township Linden

Village _____

City _____

Registration District No. 185

Primary Registration District No. 5259

File No. _____

Registered No. 13

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

FULL NAME Hensyetta Horn

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH _____
Month _____ Day _____ Year _____

AGE _____
IF LESS than 1 day _____ hrs _____ min _____
_____ yrs _____ mos _____

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) _____

THE ABOVE IS THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

FILED July 8 1914 R. M. Farthing
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 30 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ 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:

Septicemia Purpura
Capillary Birth
(Duration) _____ yrs _____ mos _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs _____ mos _____ ds.
(Signed) R. M. Farthing M. D.
Feb. 30 1914 (Address) Sparta 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 _____

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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15599

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