

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

PLACE OF DEATH
County Adair
Township Beason Registration District No. 4 File No. 18427
or
Village _____ Primary Registration District No. 3001 Registered No. 196
or
City Keokuk (NO. 2809 Hospital St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Miss Minnie Tarell

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED OR WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>May 8, 1868</u> (Month) (Day) (Year)		
AGE <u>46</u> yrs. # mos. # ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>herself</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Eric Perma</u>		
PARENTS	NAME OF FATHER <u>M. J. Tarell</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Perma</u>	
	MAIDEN NAME OF MOTHER <u>Phoebe Tarell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>May, Iowa</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) <u>W. J. Tarell</u>		
(ADDRESS) <u>Samuel Kan</u>		
Filed <u>6 1</u> 19 <u>14</u> <u>W. J. Parrish</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 1, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 16, 1914, to June 1, 1914, that I last saw her alive on June 1, 1914, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:
nephritis (acute)
(following chronic)

(Duration) 10 yrs. # mos. # ds.
Contributory Fibroid tumors
(Secondary) (Duration) 15 yrs. # mos. # ds.

(Signed) Geo. Steele M. D.
June 1, 1914 (Address) Keokuk

*State the Disease Causing Death, or, in deaths from Violent Cause, 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 4 yrs. # mos. # ds. In the State 15 yrs. # mos. # ds.
Where was disease contracted if not at place of death? Samuel Kan

Former or usual residence Samuel Kan

PLACE OF BURIAL OR REMOVAL <u>Samuel Kan</u>	DATE OF BURIAL <u>6 2</u> 19 <u>14</u>
UNDERTAKER <u>Davis Wilson</u>	ADDRESS <u>Keokuk</u>

MARGIN RESERVED FOR BINDING

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.

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*, *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, 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.)

HUGH STEPHENS, JEFFERSON CITY.



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WHILE FADING INK—THIS IS A PERMANENT RECORD

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 CERTIFICATE OF DEATH

County Adair PLACE OF DEATH _____
 Township _____ Registration District No. H. File No. 18427
 or _____
 Village _____ Primary Registration District No. 3001 Registered No. 196
 or _____
 City Kirksville (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Miss Minnie X Turrell X

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>F</u>	COLOR OF RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>June 1, 1914</u> (Month) (Day) (Year)		
DATE OF BIRTH _____ (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the _____ date stated above, at _____ m.		
AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.	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) _____			Satisfactory Information Supplied.		
BIRTHPLACE (City or town, State or foreign country) _____			(Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER <u>M. J. Turrell X</u>		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		(Signed) _____ M. D.		
	MAIDEN NAME OF MOTHER _____		_____ 191____ (Address) _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
(Informant) <u>Miss Gottgren</u>			Where was disease contracted If not at place of death? _____		
(ADDRESS) <u>Garnett Kas.</u>			Former or usual residence _____		
FILED <u>Nov 9 1914</u> <u>W. L. Parrish</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL _____		DATE OF BURIAL _____ 191____
			UNDERTAKER _____		ADDRESS _____ Supplied

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

Revised United States Standard Certificate of Death

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

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