

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 Haight  
Township Gasconade  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 907 File No. 21659  
Primary Registration District No. 6221 Registered No. 31

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

FULL NAME Sarah E. Hennis

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>married</u>
DATE OF BIRTH <u>Apr 12, 1853</u> (Month) (Day) (Year)		
AGE <u>61 yrs. 2 mos. 2 ds.</u>		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>Industrious</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Iowa, 31A 82A</u>		
PARENTS	NAME OF FATHER <u>Nathan Osborn</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Olds</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 14, 1914  
(Month) (Day) (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 10 P.M.  
The CAUSE OF DEATH\* was as follows:  
No physician in attendance  
Paralysis - This the last attack  
being the 3rd attack.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.  
Contributory Paralysis  
(SECONDARY) (Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) B. E. Latimer M. D.  
June 14, 1914 (Address) Hartsville 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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted  
If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Francis M. Hennis  
(ADDRESS) Hartsville Mo.

PLACE OF BURIAL OR REMOVAL <u>Pa. Ridge Cemetery</u>	DATE OF BURIAL <u>June 15, 1914</u>
UNDERTAKER <u>A. P. Welch</u>	ADDRESS <u>Hartsville</u>

Filed June 15, 1914 J. A. Fuson  
REGISTRAR

# 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 whatsoever, 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.)

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PLACE OF DEATH

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

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

County Wright  
Governors  
Township \_\_\_\_\_  
or  
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or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 907 File No. \_\_\_\_\_  
Primary Registration District No. 6221 Registered No. 31

FULL NAME Sarah E. Nevins [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH June 14, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1914, to \_\_\_\_\_, 1914, that I last saw him \_\_\_\_\_, 1914, 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: No Phys in attend. Paralysis

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

This the last attack had the 3rd attack, Bulbar Paralysis

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

Contributory (SECONDARY) Paralysis (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. A. Johnson Reg. M.D. June 14, 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_

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? \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Former or usual residence \_\_\_\_\_

Filed Jun 15 1914 J. A. Johnson REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 1914

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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