

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.

PLACE OF DEATH

County Bates

Township _____

or

Village _____

or

City Adrian

(NO. _____)

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
Registration District No. 47 File No. 21758Primary Registration District No. 4027 Registered No. 17

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

FULL NAME Allie Baker

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (If write the word)
Married

DATE OF BIRTH

Jan81861

(Month)

(Day)

(Year)

AGE

53

yrs.

5

mos.

26

ds.

 IF LESS than
 1 day, ____ hrs.
 or ____ min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town,

State or foreign country)

Mo

PARENTS

NAME OF FATHER

Geo Colbert

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

N Carolina

MAIDEN NAME OF MOTHER

Emmie Winfrey

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

N Carolina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R E Baker

(ADDRESS)

Adrian Mo

Filed

7-51914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July

(Month)

4

(Day)

1914

(Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914,

that I last saw him alive on _____, 191____,

and that death occurred, on the date stated above, at _____ p.m.

The CAUSE OF DEATH* was as follows:

Cancer.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

E E Robinson

M. D.

 July 5, 1914 (Address) Adrian 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

Longack Mo

DATE OF BURIAL

July 6, 1914

UNDERTAKER

H Y Carr

ADDRESS

Adrian Mo

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.)



PLACE OF DEATH

REGISTRARS SHALL NOT RE-
CEIVE 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

Bates

Township

Registration District No.

File No.

Village

Primary Registration District No.

Registered No.

City

(NO.)

St.

Ward)

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

FULL NAME

Alice Baker

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

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
FATHERBIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

File

8-29

1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)

(Day)

1914
(Year)

HEREBY CERTIFY, that I attended deceased from

1914, to

1914,

that I last saw h

on

1914,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cancer of breast left

43

(Duration)

2

mos

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos

ds.

(Signed)

M. D.

7/5

1914

(Address) Adam 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

UNDERTAKER

ADDRESS

Original file, date JUL 1914

All information called for must be written on this Supplementary Certificate.

N. B.—Every in official 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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21758