

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 Jefferson
Township Central
or
Village Hillsboro
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. H 22 File No. 23073
Primary Registration District No. 4230 Registered No. _____

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

FULL NAME Minerva J Mockler

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH June 22, 1914
(Month) (Day) (Year)

DATE OF BIRTH Apr 11, 1835
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to June 22, 1914, that I last saw he alive on June 22, 1914, and that death occurred, on the date stated above, at 7 A m.

AGE 79 yrs. 2 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:
Chronic Bright's disease
& Intermittent of
old age 150
(Duration) ____ yrs. ____ mos. ____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work 131
(b) General nature of industry, business, or establishment in which employed (or employer) 97
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Contributory Sclerosis of Arteries
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

BIRTHPLACE (City or town, State or foreign country) Jefferson Mo

PARENTS
NAME OF FATHER Landon Williams
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know
MAIDEN NAME OF MOTHER Elizabeth County
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

(Signed) G M Mockler M. D.
July 2, 1914 (Address) Hillsboro

*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) X
(ADDRESS) J

Where was disease contracted if not at place of death? _____
Former or usual residence _____

Filed July 2, 1914 G M Mockler
REGISTRAR

PLACE OF BURIAL OR REMOVAL Iron Cemetery DATE OF BURIAL Jun 23 1914
UNDERTAKER E. C. well ADDRESS Debets 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, 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 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.)

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

PLACE OF DEATH
 County Jefferson
 Township Hillsboro
 or Village
 or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. H 22 File No. _____
 Primary Registration District No. H 250 Registered No. _____

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

FULL NAME Minerva Mockbes

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF RACE W. SINGLE Widowed
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)
 DATE OF BIRTH Apr 11th 1835
 (Month) (Day) (Year)
 AGE 79 yrs. 2 mos. 2 wks. 2 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) Jefferson Mo

NAME OF FATHER Randolph Williams

BIRTHPLACE OF FATHER (City or town, State or foreign country) Jefferson Mo

MAIDEN NAME OF MOTHER Elogeth Corley

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) G M Mockbes

(ADDRESS) Hillsboro

Filed July 2 1914 G M Mockbes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 22 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Salsfactory to June 22, 1914, that I last saw him alive on June 22, 1914, and that death occurred, on the date stated Supplied, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Brights
discovered on
Info on mother of old age

Contributory Sclerosis
 (SECONDARY) (Duration) Supplied yrs. Supplied mos. Supplied ds.

(Signed) G M Mockbes M. D.
July 2 1914 (Address) Hillsboro

*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 Salsfactory Cemetery

DATE OF BURIAL July 23 1914

UNDERTAKER E. Cozwell ADDRESS Supplied

No. _____ 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.

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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.)

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