

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 Cass
Township Union
or Village Cleveland
or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 149 File No. 28720
Primary Registration District No. 4083 Registered No. 7

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

FULL NAME Emily S Bohle

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Nov 26, 1849
(Month) (Day) (Year)
AGE 64 yrs. 9 mos. 29 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Housewife 92
(b) General nature of industry, business, or establishment in which employed (or employer) 95
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3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 25, 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Jan 26, 1910, to Sept 20, 1914, that I last saw her alive on Sept 22, 1914, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH was as follows:
Heart Disease

Several years (Duration) yrs. mos. ds. V
Contributory Rheumatism
Several years (Duration) yrs. mos. ds.
(Signed) H P Guthrie M. D.
Sept 25, 1914 (Address) Cleveland Mo

BIRTHPLACE (City or town, State or foreign country) Randolph Co NC
NAME OF FATHER George Kinney
BIRTHPLACE OF FATHER (City or town, State or foreign country) Randolph Co NC
MAIDEN NAME OF MOTHER Ruth McMaster
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Randolph Co NC

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ranfin Bohle
(ADDRESS) Cleveland Mo
Filed Sept 25, 1914 H P Guthrie REGISTRAR

PLACE OF BURIAL OR REMOVAL Cleveland Cem DATE OF BURIAL Sept 27, 1914
UNDERTAKER H L Williams ADDRESS Louisburg 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, 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," "Uræmia," "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.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Cass

Township _____

or Village Cleveland

or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 149

File No. _____

Primary Registration District No. 4083

Registered No. # 4

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

FULL NAME

Emily S. Coker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Sept 25, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, that I last saw h. _____ alive on _____, 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:
Heart Dis.
Mitral Incompetency

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 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) Rheumatism
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H.P. Guthrie M. D.
Sept 25, 1914 (Address) Cleveland Mo.

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

*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 _____

(ADDRESS) _____
FILE 9/25 1914 H.P. Guthrie REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____

SEP 1914

Revised United States Standard Certificate of Death

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

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