

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

PLACE OF DEATH

County Cooper
Township Clear Creek
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 223 File No. 28831
Primary Registration District No. 5304 Registered No. 9

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

FULL NAME Leona Schoen

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>April 16, 1908</u> (Month) (Day) (Year)		
AGE <u>6 yrs. 4 mos. 4 ds.</u> If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>186A</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>194B</u>		

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 20, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 18, 1914 to Aug 20, 1914, that I last saw her alive on Aug 20, 1914, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Fracture Skull

(Duration) ___ yrs. ___ mos. 2 ds.

Contributory
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. S. Barry M. D.
supra, 1914 (Address) Pilot Grove 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 Clear Creek C. DATE OF BURIAL Aug 21, 1914

UNDERTAKER Elliott & Chapman ADDRESS Pilot Grove Mo

BIRTHPLACE (City or town, State or foreign country) Clear Creek Twp.

NAME OF FATHER Mike Schoen

BIRTHPLACE OF FATHER (City or town, State or foreign country) Clear Creek Twp.

MAIDEN NAME OF MOTHER Mary M. Woolledge

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pilot Grove Twp.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philomena Schoen

(ADDRESS) Pilot Grove Mo.

Filed Sept 9, 1914 J. S. Parrish

REGISTRAR

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, 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.)

PLACE OF DEATH

County

Cooper

Township

Clear Creek

Village

City

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

Registration District No.

223

Primary Registration District No.

5304

File No.

Registered No.

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

FULL NAME

Leona Schouy

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)S

DATE OF BIRTH

(Month) (Day) (Year)

AGE

yrs. mos. 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)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

9/9

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J. J. Parrish

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) (Day) (Year)

Aug 20, 1914

I HEREBY CERTIFY, that I attended deceased from _____, 191____, and that death occurred, on the date stated above, at _____, 191____. Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Inertive Skull from fall of Cerebritis
Accidental (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Aug 20, 1914 (Address) _____ M. D. _____

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was dispost contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Original file, date

SEP - 1914

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

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1922

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