

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Macon ✓
Township Lige Registration District No. 576 File No. 29712
or
Village _____ Primary Registration District No. 4312 Registered No. _____
or
City Atlanta Mo (NO. _____) St. _____ Ward _____

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

FULL NAME Grace Ethel Cambre

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH July 28, 1884
(Month) (Day) (Year)

AGE 30 yrs. 1 mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Manchester Iowa

PARENTS
NAME OF FATHER J. H. Priest
BIRTHPLACE OF FATHER Wis.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Kellie A. Clemming
BIRTHPLACE OF MOTHER Mich.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wilson
(ADDRESS) Water Line Iowa

Filed Sept 19, 1914 J. M. Halleburton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 12, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 1, 1914, to Sept. 12, 1914, that I last saw her alive on Sept. 12, 1914, and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia

108 (Duration) yrs. mos. ds.

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

Signed O. H. Brexey, M. D.
Sept. 13, 1914 (Address) La Plata 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 Fort Madison Iowa DATE OF BURIAL Sept 13, 1914

UNDERTAKER Hughes & Co ADDRESS Atlanta, Mo

N. B.—Every item of information should be carefully applied. 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 _____
Township _____
or _____
Village _____
or _____
City _____

Registration District No. _____
Primary Registration District No. _____
St. _____ Ward _____

File No. _____
Registered No. _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE _____ yrs., _____ mos., _____ ds.
IF LESS than _____ hrs. _____ min.?
1 day, _____ hrs. _____ 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 _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____
Filed _____, 191____, _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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 _____ m.
The CAUSE OF DEATH was as follows:

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

Contributory _____ (SECONDARY) _____
(Signed) _____ (Address) _____, 191____ M. D. _____
(Duration) _____ yrs., _____ mos., _____ ds.

*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 _____ yrs., _____ mos., _____ ds. 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 _____, 191____
UNDERTAKER _____ ADDRESS _____

RECORD WITH ORIGINAL INFO - THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
 County Macou
 Township _____
 or
 Village _____
 or
 City Atlanta Mo

Registration District No. 526 File No. _____
 Primary Registration District No. 4312 Registered No. _____
 St.: _____ Ward) _____

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

FULL NAME Grace Ethel Lamb

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE <u>M</u> MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____		AGE _____
OCCUPATION (a) Trade, profession, or particular kind of work _____		IF LESS than 1 day, _____ hrs. or _____ min.
BIRTHPLACE (City or town, State or foreign country) _____		OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer) _____
PARENTS	NAME OF FATHER _____	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	MAIDEN NAME OF MOTHER _____
	MAIDEN NAME OF MOTHER _____	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	

DATE OF DEATH Sept. 12 1914
 (Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____, 191____, and that death occurred, on the date _____, at _____ m. The CAUSE OF DEATH* was as follows:
Pneumonia. Lobar

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

(Signed) Sept. 13 1914 (Address) La Plata Mo

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) the Cause 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) _____
 (ADDRESS) _____
 Filed Sept 29 1914 Jmt Gallen REGISTRAR

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

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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

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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.)