

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 Brown
Township Cedar or Village or City (NO. _____) (St. _____ Ward _____)
Registration District No. 26 File No. 31465
Primary Registration District No. 5418-B Registered No. 9

FULL NAME Willie Mathews

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>Oct 7, 1914</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>July 10, 1839</u> (Month) (Day) (Year)			I HEREBY CERTIFY that I attended deceased from <u>Knowlton, Mo., 1914</u> , 191 <u>4</u>	
AGE <u>75 yrs. 2 mos. 27 ds.</u>			that I last saw h. <u>alive on</u> <u>Sept 1914</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u>			and that death occurred, on the date stated above, at <u>East Union</u> m.	
(b) General nature of industry, business, or establishment in which employed (or employer)			The CAUSE OF DEATH* was as follows: <u>Murdered</u> <u>175th</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Ind.</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Amner Arnold</u>		Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ind.</u>		(Signed) <u>Ed. S. Davis</u> M.D. <u>Oct. 7, 1914</u> (Address) <u>Columbus, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Mollie Johnson</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ind.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Frank Mathews</u>			Where was disease contracted If not at place of death?	
(ADDRESS) <u>Hartsville, Mo.</u>			Former or usual residence	
Filed <u>Oct 8, 1914</u> <u>O. O. Gorman</u>			PLACE OF BURIAL OR REMOVAL <u>Private Cemetery</u> <u>Oct. 8, 1914</u>	
REGISTRAR			UNDERTAKER <u>Ben Johnson Ashland Mo.</u>	
			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, 8 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," "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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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Boone
Township Cedar
or
Village _____
or
City _____ (NO _____)

Registration District No. 76
Primary Registration District No. 5710B

File No. _____
Registered No. 9

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

FULL NAME Millie Mathews

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

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

AGE _____
If LESS than 1 day, _____ hrs. or _____ min. _____ yrs. _____ mos. _____ ds.

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) _____

File Oct. 8 1914 G. O. Bruner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 7 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1914, that I last saw h _____ alive on _____, 1914, and that death occurred, on the date stated above, at _____.
The CAUSE OF DEATH* was as follows:
Murdered
Skull crushed with
some blunt instrument

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

(Signed) G. O. Bruner M.D.
10/17 1914 (Address) Columbia, 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 _____ 1914

UNDERTAKER _____ ADDRESS _____

Supplementary Information Supplied

Revised United States Standard Certificate of Death

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

Sepsis

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