

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

PLACE OF DEATH

County Boiler
Township Beaver-dam
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 87

File No. 31584

Primary Registration District No. 5129

Registered No. 28

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

FULL NAME Amancia Elizabeth Bacheles

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)
DATE OF BIRTH <u>May 9th 1848</u> (Month) (Day) (Year)		
AGE <u>66</u> yrs. <u>5</u> mos. <u>6</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>General</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>		
PARENTS	NAME OF FATHER <u>Ambrose Stafford</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Link</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 15, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 14, 1914, to Oct 15, 1914, that I last saw her alive on Oct 15, 1914, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
82A
97
(Duration) yrs. mos. 2 ds.

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

(Signed) R. L. Turner M. D.
Oct 15, 1914 (Address) Havill 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 Kinsey Cemetery DATE OF BURIAL Oct 17, 1914

UNDERTAKER Reed & Co ADDRESS Naylor, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. S. Redman
(ADDRESS) Loft Mo

Filed 10-15, 1914, R. L. Turner 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.)

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 CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Butler
Township Beaver Dam
or
Village
or
City (NO. _____)

Registration-District No. 87 File No. _____
Primary Registration District No. 5129 Registered No. 23
St.: _____ Ward _____

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

FULL NAME Amanda Elizabeth Batcheler

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 10-15 1914 R L Turner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 15 1914
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive _____ 191____, and that death occurred, on the date stated above, at _____ m.

CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage caused by Arterio sclerosis
(Duration) 64 mos. ds.

Contributory (Secondary) _____ (Duration) _____ mos. ds.
(Signed) R L Turner (Address) Harvell 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 _____ 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 _____

SUPPLEMENTARY Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

S-31584

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