

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: Dallas *Dr. Armstrong*
Township: North Benton Registration District No. 241 File No. 31865
or Village: Buffalo Primary Registration District No. 5334 Registered No. 121
or City: _____ (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Quisenberry

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH <u>Sept 3, 1873</u> (Month) (Day) (Year)		
AGE <u>40</u> yrs. <u>6</u> mos. <u>29</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) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>		
PARENTS	NAME OF FATHER <u>Jno Ruvoel</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	
	MAIDEN NAME OF MOTHER <u>Mary Harmon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 2, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-15, 1914, to March 15, 1914, that I last saw her alive on March 15, 1914, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:
Cronic Parden

(Duration) _____ yrs. 3 mos. _____ ds.

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

(Signed) M. J. Armstrong M. D.
4-3, 1914 (Address) Buffalo 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Quisenberry
(ADDRESS) Buffalo
Filed Oct 1, 1914 J. Phillip
REGISTRAR

PLACE OF BURIAL OR REMOVAL Reynolds Cemetery DATE OF BURIAL 4-3-1914
UNDERTAKER C. W. Smith ADDRESS Buffalo 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," "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.)

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

PLACE OF DEATH

County

Dallas
N. Benton

Registration District No.

241

File No.

or
Village

Primary Registration District No.

5334

Registered No.

121

or
City

(No.

St.

Ward)

FULL NAME

Sarah Luscomb

[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

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

F

W.

M.

Apr. 2, 191*4*
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

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

I HEREBY CERTIFY, that I attended deceased from _____, 191*4*, to _____, 191*4*, that I last saw _____, 191*4*, and that death occurred, on the date stated above.

THE CAUSE OF DEATH* was as follows:

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Chronic Parau
Valvular heart disease

BIRTHPLACE

(City or town, State or foreign country)

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)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) *M. F. Armstrong* M. D.
H. T. G. 191*4* (Address) *Buffalo, 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 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

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

Oct 1 191*4* *J. Phillips*

REGISTRAR

Satisfactory Information Supplied.
 SUPPLEMENTARY
 Satisfactory Information Supplied.

Satisfactory Information Supplied.
 Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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