

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.

PLACE OF DEATH

County Merion

Township _____
or _____

Village _____
or _____

City of Hannibal

Registration District No. 5217

Primary Registration District No. 3029

(NO. Loving Hospital)

File No. 32842

Registered No. 259

St. 6 Ward _____

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

FULL NAME Mary S. Howald

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

$\frac{10}{2}$

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
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DATE OF DEATH Oct. 27, 1914
(Month) (Day) (Year)

DATE OF BIRTH Dec. 27, 1859
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 2, 1914, to Oct 26, 1914, that I last saw her alive on Oct 26, 1914, and that death occurred, on the date stated above, at 3³⁹ a.m.

AGE 54 yrs. 10 mos. ds.
If LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:

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

Cholelithiasis

BIRTHPLACE
(City or town, State or foreign country) Pike Co. Mo.

126
127B
120B (Duration) 1 yrs. ____ mos. ____ ds.
Contributory _____
(SECONDARY)

NAME OF FATHER William Devlin

BIRTHPLACE OF FATHER
(City or town, State or foreign country) State Kentucky

MAIDEN NAME OF MOTHER Elizabeth Lewellen

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Pike Co. Mo.

(Signed) J. P. Bowen M. D.
1927, 1914 (Address) Hannibal Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lizzie A. Spuler

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 _____

(ADDRESS) Center Mo.

PLACE OF BURIAL OR REMOVAL Center Mo. DATE OF BURIAL Oct. 28, 1914

Filed Oct 27, 1914 M. H. Jones REGISTRAR

UNDERTAKER Wm. M. Smith ADDRESS Hannibal

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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
County Marion

Township _____

or

Village _____

City Hamburg (NO. _____)

Registration District No. 547

Primary Registration District No. 3029

File No. _____

Registered No. 259

Ward _____

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

FULL NAME Mary S. Howoed

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

DATE OF DEATH Oct 27, 1914

(Month)

(Day)

(Year)

DATE OF BIRTH _____

(Month)

(Day)

(Year)

AGE _____

If LESS than 1 day, hrs. or min. _____

I HEREBY CERTIFY, that I attended deceased from _____, 1914, that I last saw him alive on _____, 1914, and that death occurred, on the date stated above, at _____.

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) _____

Cholelithiasis
Biliary Calculi, ulcerated
through duct & bowels

BIRTHPLACE

(City or town, State or foreign country) _____

(Duration) _____

yrs. _____

mos. _____

ds. _____

NAME OF FATHER _____

Contributory _____

(SECONDARY)

(Duration) _____

yrs. _____

mos. _____

ds. _____

BIRTHPLACE OF FATHER _____

(Signed) J. S. Bourne

1914

(Address) _____

M. D.

MAIDEN NAME OF MOTHER _____

*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 _____

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) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

1914

Filed Oct 27, 1914

1914

REGISTRAR

UNDERTAKER _____

ADDRESS _____

Original file, date 1914

100 1914

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

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.

Satisfactory Information Supplied.
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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