

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

33045

PLACE OF DEATH
County Remick
Township Holland
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1127 File No. 22
Primary Registration District No. 6281 Registered No. 22

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

FULL NAME Mary J. Pledsoe

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 BIRTH <u>8</u> <u>25</u> <u>1882</u> (Month) (Day) (Year)		
AGE <u>62</u> yrs. <u>1</u> mos. <u>8</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?

DATE OF DEATH
10 3 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 9/10, 1914, to 10/3, 1914, that I last saw her alive on 10/3, 1914, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Flux

11 B

1.3 C (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) William S. Robinson M. D.
10/4 1914 (Address) Holland 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 _____

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

BIRTHPLACE
(City or town, State or foreign country) Hickman County, Tenn.

PARENTS	NAME OF FATHER <u>Yabe. Jones</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hickman County, Tenn.</u>
	MAIDEN NAME OF MOTHER <u>Neely, Glass</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Hickman County, Tenn.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. F. Pledsoe

(ADDRESS) Holland Mo

Filed Oct. 4 1914 J. S. Pledsoe REGISTRAR

PLACE OF BURIAL OR REMOVAL
Danford Cemetery

DATE OF BURIAL
Oct 5 1914

UNDERSEALER
J. S. Pledsoe

ADDRESS
Holland 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*, *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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County

*Leuescot
Holdau*

Registration District No.

1127

File No.

27

Township
or
Village

Primary Registration District No.

6281

Registered No.

22

City

(NO. _____ St. _____ Ward _____)

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

FULL NAME

Mary J. Bledsoe

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

F

W

M

DATE OF DEATH

Oct. 3 4
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

IF LESS than 1 day, hrs. min. yrs. mos. ds.

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

The CAUSE OF DEATH* was as follows: *Supplied*

Slut & Bloods following a gripp of bowels
(Duration) 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)

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.

(Signed) *William J. Robinson* 1914 (Address) *Holdau 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)

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Filed

191

REGISTRAR

Original file, date

OCT 1914

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

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SUPPLEMENTARY Information Supplied

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Revised United States Standard Certificate of Death

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

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