CAUSE OF DEATH is 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: Pettis

Township: ____ or Village: ____ or City: Sedalia (NO. ____ St.: ____ Ward)

Registration District No. 668 — File No. 33090

Primary Registration District No. 3132 — Registered No. 256

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

FULL NAME: Maude Grave

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Female — COLOR OR RACE: Negro — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): ✓

DATE OF BIRTH: Aug (Month) 431 (Day), 1888 (Year)

AGE: 26 yrs. 2 mos. 22 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Fort Scott Kan

PARENTS
NAME OF FATHER: Geo Julin
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn
MAIDEN NAME OF MOTHER: Jenny Doso
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Texas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Jones
Fort Scott Kan
(ADDRESS) 616 Short St

Filed Oct. 26, 1914 — F. B. Long, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Oct (Month) 22 (Day), 1914 (Year)

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

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage
23 H
23 E (Held Autopsy) 28
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): Pulmonary Tuberculosis
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W A Beckemeyer M. D.
Oct 23 1914 (Address) Sedalia Acting Coroner

*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: Fort Scott Kansas — DATE OF BURIAL: ____ 1914

UNDERTAKER: Wm Alexander — ADDRESS: Sedalia 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 *septichaemia*," "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.)

PLACE OF DEATH

County Pettis

Township

or

Village

or

City Sedalia (NO. St.: Ward)

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

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

Registration District No. 668 File No.

Primary Registration District No. 3032 Registered No. 256

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

FULL NAME Maude Grave

### PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE B

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) X married

DATE OF BIRTH ..., 1 (Month) (Day) (Year)

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

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) Franvie Jones

(ADDRESS) Fort Scott Kansas 616 Short St.

Filed Oct 26 1914 J H Mitchell Reg. REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 22, 1914 (Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:

(Duration) ... yrs. ... mos. ... ds.

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

(Signed) ... M. D.

..., 191... (Address)

*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 ..., 191...

UNDERTAKER

ADDRESS

Original file, date ..., 19... All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Satisfactory Information Supplied

# Revised United States Standard Certificate of Death

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

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