

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

PLACE OF DEATH

County Scott

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City Chaffee Mo (NO. \_\_\_\_\_)

Registration District No. 816

File No. 34293

Primary Registration District No. 4492

Registered No. 47

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

Bertha Mae Laughlin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

White

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

DATE OF DEATH

Oct. 25, 1914  
(Month) (Day) (Year)

DATE OF BIRTH

Sept 22, 1909  
(Month) (Day) (Year)

AGE

5 yrs. 1 mos. 3 ds.  
If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION

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

Child

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

11

BIRTHPLACE

(City or town, State or foreign country)

Chaffee Mo

PARENTS

NAME OF FATHER

R. T. Laughlin

BIRTHPLACE OF FATHER

Groby Mo

MAIDEN NAME OF MOTHER

H. M. Ansell

BIRTHPLACE OF MOTHER

Fish Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

J. E. Ansell  
Chaffee Mo

Filed

Oct. 25, 1914  
J. G. Sample  
REGISTRAR

HEREBY CERTIFY, that I attended deceased from

Oct. 13, 1914 to Oct. 25, 1914,  
that I last saw her alive on Oct. 14, 1914

and that death occurred, on the date stated above, at 7:30 am.

The CAUSE OF DEATH\* was as follows:

Congenital Heart Disease  
1.57C

(Duration) 5 yrs. 1 mos. 3 ds.

Contributory

(SECONDARY)

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed)

J. G. Sample M. D.  
Oct. 26, 1914 (Address) Chaffee 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 at various times during life in the of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Denia Cemetery

DATE OF BURIAL

10/26, 1914

UNDERTAKER

H. J. Stubbs

ADDRESS

Chaffee Mo

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.)

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 Scott

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Chaffee (NO. \_\_\_\_\_)

Registration District No. 816 File No. \_\_\_\_\_

Primary Registration District No. 4492 Registered No. 47

FULL NAME Bertha McLaughlin (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 F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Single (If write the word)

DATE OF DEATH Oct. 25, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

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, \_\_\_\_\_ m.

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

CAUSE OF DEATH\* was as follows:  
Congenital Heart Disease  
Stent Proximal Craters  
Congenital malformation  
Heart (Duration) 5 yrs. 1 mos. 3 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 of foreign country \_\_\_\_\_)

PARENTS NAME OF FATHER \_\_\_\_\_ BIRTHPLACE OF FATHER (City or town, State of foreign country) \_\_\_\_\_ MAIDEN NAME OF MOTHER \_\_\_\_\_ BIRTHPLACE OF MOTHER (City or town, State of foreign country) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Chaffee Mo. (Address) Chaffee Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ (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 \_\_\_\_\_

File No. Oct. 25, 1914 G. S. Sample REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_ UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY Certificate Information Supplied.

Satisfactory Information Supplied.

# Revised United States Standard Certificate of Death

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

34293

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