

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

PLACE OF DEATH
County Scott Mo
Township Richland
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 821 File No. 34309
Primary Registration District No. 6070 Registered No. 72

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

FULL NAME Emma May Moyers

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Infant
(# rit. the word)
DATE OF BIRTH Aug 17, 1910
(Month) (Day) (Year)
AGE 4 yrs 3 mos 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH Oct 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 14, 1914, to Oct 21, 1914, that I last saw her alive on Oct 21, 1914, and that death occurred, on the date stated above, at 11:40 p.m.

The CAUSE OF DEATH* was as follows:
Diphtheria

BIRTHPLACE (City or town, State or foreign county) Keosauqua Mo

7 1/2 (Duration) yrs. mos. ds.
12 1/2 B

PARENTS
NAME OF FATHER Samuel Moyers
BIRTHPLACE OF FATHER (City or town, State or foreign country) Keosauqua Mo
MAIDEN NAME OF MOTHER One Sudder
BIRTHPLACE OF MOTHER (City or town, State or foreign county) Keosauqua Mo

Contributory Diphtheria Meningitis
(SECONDARY) (Duration) yrs. mos. ds. 2

(Signed) W. Miller M. D.
Oct 21, 1914 (Address) Keosauqua 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) Samuel Moyers
(ADDRESS) Keosauqua Mo

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 4 yrs 2 mos 4 ds. In the State 4 yrs 3 mos 4 ds.

Where was disease contracted if not at place of death?
Former or usual residence Keosauqua Mo

Filed Oct 21, 1914 P. M. Malcolin REGISTRAR

PLACE OF BURIAL OR REPOUSE Keosauqua Mo DATE OF BURIAL Oct 21, 1914
UNDERTAKER J. H. Allderton ADDRESS Keosauqua Mo

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, 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 "*Asithenia, "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

Township

or

Village

or

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

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

FULL NAME

Anna May Moyers

PERSONAL AND STATISTICAL PARTICULARS

SEX *F* COLOR OR RACE *W.* SINGLE MARRIED WIDOWED OR DIVORCED *S*
(Write the word)

DATE OF BIRTH *1* (Month) *1* (Day) *1914* (Year)

AGE *1* yrs. *1* mos. *1* ds. IF LESS than 1 day, *1* hrs. or *1* 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)

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)

(ADDRESS)

Filed *Oct 21 1914* *PM* *Mahesh* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Oct. 21* 191*4*
(Month) (Day) (Year)

I SATISFACTORILY CERTIFY, that I attended deceased from *1914* to *1914*, that I last saw h *1914* alive on *1914*, and that death occurred, on the date stated above, at *1914* m.

The CAUSE OF DEATH* was as follows:
Acute Colitis
was not Epidemic nor
Infectious (Duration) *1* yrs. *7* mos. *7* ds.

Contributory *Menigitis* (SECONDARY) (Duration) *2* yrs. *2* mos. *2* ds.

(Signed) *Oct 21 1914* (Address) *Liberton 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 *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted if not at place of death? Former or usual residence.

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *1914*

UNDERTAKER ADDRESS

SATISFACTORY INFORMATION SUPPLIED

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

34309

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