

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

PLACE OF DEATH Cooper
County _____
Township _____
OR
Village _____
OR
City Pilot Grove (NO. _____) St. _____ Ward _____

Registration District No. 244 File No. 83850
Primary Registration District No. 4130 Registered No. 18

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

FULL NAME Edwina Davis

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|---|
| SEX <u>Female</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word) |
| DATE OF BIRTH <u>Aug 18, 1908</u> (Month) (Day) (Year) | | |
| AGE <u>6 yrs 4 mos ds.</u> | | 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) <u>Boonville Mo</u> | | |
| PARENTS | NAME OF FATHER <u>B. W. Davis</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u> | |
| | MAIDEN NAME OF MOTHER <u>Emma Bennett</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u> | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 18, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 8, 1914, to Dec 18, 1914 that I last saw her alive on Dec 17, 1914, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

Encephalitis
10 1/2 (Duration) yrs mos 6 ds.
Contributory Menstruation
(SECONDARY) (Duration) yrs mos 4 ds.
(Signed) W. S. Barnes M. D.
Dec 18, 1914 (Address) Pilot Grove 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) Ellis Davis
(ADDRESS) Boonville Mo
Filed Dec 19, 1914 J. O. Pundleton
REGISTRAR

PLACE OF BURIAL OR REMOVAL Pilot Grove Cem DATE OF BURIAL Dec 19, 1914
UNDERTAKER Elliot Chapman ADDRESS Pilot Grove

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.)

County Cooper

Township _____

Registration District No. 272 File No. _____

Village _____

Primary Registration District No. 4130 Registered No. 18

City Pilot Grove (NO. _____)

St.: _____ Ward) _____

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

FULL NAME Edwine Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

DATE OF BIRTH _____
(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) _____

(ADDRESS) _____

Filed Jan 19 1918 - T. O. Audette REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 18 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917, to _____, 1917, that I last saw h. _____ alive on _____, 1917, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory meningitis
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. S. Barnes M.D.
Dec 18, 1917 (Address) Pilot Grove 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 5 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 _____ 1917

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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