

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

1 PLACE OF DEATH

County Green
Township Franklin
or
Village
or
City

Registration District No. 322
Primary Registration District No. 5446

File No. 38613
Registered No. ~~322~~ 32

2 FULL NAME Minerva Peck

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Apr 19 1854
(Month) (Day) (Year)

7 AGE 53-7 yrs. 7 mos. 10 ds. IF LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS
10 NAME OF FATHER J. W. Gortley
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
12 MAIDEN NAME OF MOTHER Nancy McBlair
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Taylor
(Address) Trail Bon Road

15 Filed Dec 1 1914 Registrar M. T. Edmondson

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 5 1914 to Nov 30 1914, that I last saw her alive on Nov 29 1914 and that death occurred, on the date stated above, at 5 1/2 m.

The CAUSE OF DEATH* was as follows:
Pluric Efusion
109A
110B
(Duration) 1 1/2 yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) M. T. Edmondson D.
Nov 30 1914 (Address) Trail Bon

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL Wm. Crawford DATE OF BURIAL Dec 1 1914

20 UNDERTAKER Wm. Crawford ADDRESS Springfield

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.)

PLACE OF DEATH

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

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County Franklin Registration District No. 322 File No. _____
 Township Franklin Primary Registration District No. 5446 Registered No. 32
 Village _____
 City _____ (No. _____ St. _____ Ward _____)
 FULL NAME Minerva Peck

(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 M
 (Write the word)
 DATE OF BIRTH _____ 191____
 (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) _____

DATE OF DEATH Nov. 30, 191____
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date stated above, at _____ m.
 (The CAUSE OF DEATH* was as follows: Puritic Emission following Pneumonia)
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) M. T. Edmondson M.D. Nov 30, 191____ (Address) Tair Town, 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 _____

SUPPLEMENTARY CERTIFICATE

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed Dec 1, 191____ M. T. Edmondson
 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

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