

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

PLACE OF DEATH

County Larison
Township Bithony
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 334 File No. 5 848
Primary Registration District No. 5465 Registered No. 3

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

FULL NAME

Cornelia Scofield

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

DATE OF DEATH Jan 10, 1915
(Month) (Day) (Year)

DATE OF BIRTH March 29, 1843
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 8, 1915, to Jan 10, 1915, that I last saw her alive on Jan 8, 1915, and that death occurred, on the date stated above, at 3 A m.

AGE 71 yrs. 9 mos. 11 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

Cerebral Hemorrhage
82A
97 64 (Duration) ___ yrs. ___ mos. 2 1/2 ds.

BIRTHPLACE (City or town, State or foreign country) Do not know

Contributory (SECONDARY) 3 (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Lottie B. Webb M. D.
Jan 11 1915 (Address) Bithony Mo.

PARENTS NAME OF FATHER Joseph Phackara
BIRTHPLACE OF FATHER (City or town, State or foreign country) Do not know
MAIDEN NAME OF MOTHER Do not know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Do not know

*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) Wm. M. Clark
(ADDRESS) Bithony Mo.

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 _____

Filed Jan 11, 1915 Lottie B. Webb REGISTRAR

PLACE OF BURIAL OR REMOVAL Bithony Country DATE OF BURIAL Jan 12, 1915
UNDERTAKER SM Clark ADDRESS Bithony 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 *septicæmia*," "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.)

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

PLACE OF DEATH

County Nampan
Township Butaway
Village _____
City _____ (MO. _____ St. _____ Ward _____)

Registration District No. 334 File No. _____
Primary Registration District No. 5465 Registered No. 3

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

FULL NAME

Conelia Scofield

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

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

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 Jan 11 1915 Lennie Webb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 10, 1915
(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 _____.

The CAUSE OF DEATH* was as follows:
Coronal Arteriosclerosis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Arteriosclerosis
(SECONDARY) (Duration) 5 yrs. _____ mos. _____ ds.

(Signed) Lennie Webb M. D. (Address) Butaway 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 _____

PLACE OF BURIAL OR REMOVAL Mon DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

STATISTICAL INFORMATION SUPPLIED BY _____
SUPPLEMENTARY

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