

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

County Pettis

Township _____

or Village _____

or City Sidalia

Registration District No. 668

File No. 2011

Primary Registration District No. 3032

Registered No. 2

(NO. Ohio + Broad Way St. 4 Ward)

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

FULL NAME Georgie A. Case

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April, 1872
(Month) (Day) (Year)

AGE 43 yrs. _____ mos. _____ ds. IF LESS than
1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Glasgow Mo

PARENTS
NAME OF FATHER Joseph Gosley
BIRTHPLACE OF FATHER Canada
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Bell do
BIRTHPLACE OF MOTHER Canada
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Case
(ADDRESS) Lincoln Mo

Filed Jan 4, 1915 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 3, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 31, 1914, to Jan 3, 1915, that I last saw her alive on Jan 3, 1915, and that death occurred, on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Tetanus
26
115 E

Contributory X
(SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. A. Wood M. D.
Jan 3, 1915 (Address) Sidalia 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 Lincoln Mo DATE OF BURIAL Jan 4, 1915

UNDERTAKER McLaughlin ADDRESS 515 Ohio St

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

County

Pettis

Township

Registration District No.

668

File No.

Village

Primary Registration District No.

3032

Registered No.

2

City (NO. St. Ward)

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

FULL NAME

Georgie R. Case

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

(Month) (Day) (Year)

AGE

IF LESS than 1 day, ___ hrs. or ___ min. or ___ yrs. ___ mos. ___ 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 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 4 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan. 3, 1915
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from

1915, to 1915,

that I last saw him alive on 1915,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tetanus

Unknown

Suspected from mos. 5 ds.

Contributory *to teeth*

(SECONDARY) (Duration) yrs. mos. ds.

(Signed) *Ed W. ...* M. D.

1-3 1915 (Address) *Sedalia 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 DATE OF BURIAL 1915

UNDERTAKER ADDRESS

Original file, date

1915

1915

19

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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1102

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