

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

PLACE OF DEATH  
County Cheney  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Salisbury (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 175 File No. 4109  
Primary Registration District No. 410X Registered No. 9

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

FULL NAME Maria Etha Cooper

**PERSONAL AND STATISTICAL PARTICULARS**

SEX F COLOR OR RACE Black SINGLE  MARRIED  WIDOWED  DIVORCED  (If write the word)

DATE OF BIRTH July 17, 1914  
(Month) (Day) (Year)

AGE 7 yrs. 2 mos. 2 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) Mo

**PARENTS**

NAME OF FATHER Earl Cooper  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo  
MAIDEN NAME OF MOTHER Will Etha Horry  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Feb 24, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1<sup>st</sup>, 1915, to Feb 24<sup>th</sup>, 1915, that I last saw her alive on Feb 19<sup>th</sup>, 1915, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH\* was as follows:  
Bronchitis followed La Grippe

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Charles J. Kelly M. D.  
Feb 24, 1915 (Address) Salisbury 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) Wm Horry  
(ADDRESS) Salisbury Mo  
Filed 4/24 1915 W. H. Hawkins REGISTRAR

PLACE OF BURIAL OR REMOVAL Salisbury Cemetery DATE OF BURIAL Feb 25, 1915  
UNDERTAKER Beulah Berry ADDRESS Salisbury

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be written in full.

# 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 "Asthemia," "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.)

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

PLACE OF DEATH

County Chariton

Township \_\_\_\_\_ or \_\_\_\_\_

Registration District No. 175 File No. \_\_\_\_\_

Village \_\_\_\_\_ or \_\_\_\_\_

Primary Registration District No. 4104 Registered No. 9

City Salisbury (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Marie Etta Carpenter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED S  
(Write the word)

DATE OF DEATH Feb 24, 1915  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h. \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date, stated above, at \_\_\_\_\_.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

CAUSE OF DEATH\* was as follows: Supplied

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

Bronchitis following a grippe. Acute  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

(Signed) J. Franklyn Welch M.D. Feb. 24, 1915 (Address) Salisbury Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_

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

MAIDEN NAME OF MOTHER \_\_\_\_\_

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

At place of death \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? \_\_\_\_\_

(Informant) \_\_\_\_\_

Former or usual residence \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

Filed 2/24 1915 - JW Hawkins REGISTRAR

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Every item of information should be carefully supplied. PHYSICIANS - All state

SUPPLEMENTARY INFORMATION SUPPLIED

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