

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 Perry
Township Bois Bull
or Village Claryville
or City _____ (NO. _____) St. _____ Ward _____

Registration District No. 1128 File No. 65657
Primary Registration District No. 5879-A Registered No. 3
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Marian Moore

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH October 16, 1844
(Month) (Day) (Year)
AGE 70 yrs. 3 mos. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Tennessee

PARENTS
NAME OF FATHER Enoch Woods
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. N. Moore
(ADDRESS) Claryville, Mo.
Filed _____ 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 9, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from November 1, 1914, to Feb 9, 1915, that I last saw her alive on Nov 1, 1914, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:
Disease of Heart
Insufficiency of mitral valve

(Duration) 8 yrs. ___ mos. ___ ds.
Contributory None
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. P. Macken M. D.
Chester, Mo. (Address)

*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 Rockwood, Ill. DATE OF BURIAL 2/10, 1915
UNDERTAKER Helge Bros. ADDRESS Chester, Ill.

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*, *Sar-*

coma, 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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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.)

HUGH STEPHENS, JEFFERSON CITY.



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

PLACE OF DEATH
 County Geny
 Township Bridwell
 or
 Village
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1128 File No. _____
 Primary Registration District No. 5870d Registered No. 3

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

FULL NAME Marion Moore

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 9, 1915
 (Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____, that I last saw h _____ alive on _____, 191_____,

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

and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

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 Apr 30, 1915 C. Harley Moore
 REGISTRAR

 (Duration) yrs. mos. ds.

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

(Signed) _____ M. D.
 _____, 191_____
 (Address)

*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 _____, 191____

UNDERTAKER

ADDRESS

Original file, date Feb 9th, 1915 Information called for must be written on this Supplementary Certificate.

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.

SATISFACTORY INFORMATION SUPPLIED

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