

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

PLACE OF DEATH

City Geny
Wardship Geny
Village _____

Registration District No. 310
Primary Registration District No. 4186
2489

File No. 8175
Registered No. 33

(NO. _____) St.: _____ Ward _____

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

FULL NAME Elizabeth Jeluska

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 12, 1915
(Month) (Day) (Year)

DATE OF BIRTH Not know exact, 19
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 11, 1915, to Feb 12, 1915, that I last saw her alive on Feb 12, 1915, and that death occurred, on the date stated above, at 3:30 P.m.

AGE not know exact, 80 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Pneumonia

OCCUPATION (a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

PLACE OF BIRTH Va

NAME OF FATHER Louis Tyler

PLACE OF BIRTH OF FATHER Va

NAME OF MOTHER Not know

PLACE OF BIRTH OF MOTHER Va

IS TRUE TO THE BEST OF MY KNOWLEDGE
Mrs Ella Gooden

ADDRESS Darlington Mo

116 1915 W. Shelby
REGISTRAR

(Duration) yrs. mos. 6 ds.

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

(Signed) A. K. Hoelst M. D.
Feb 13, 1915 (Address) Darlington 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 Long Branch DATE OF BURIAL Feb 12, 1915

UNDERTAKER A. K. Hoelst ADDRESS A. K. Hoelst

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward _____
 (If death or hospital give its of street)

**MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTIC
 CERTIFICATE OF DEATH**

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(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) _____

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 _____, 191____, _____
 REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____

I HEREBY CERTIFY, that I attended deceased
 _____, 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:

Contributory
 (SECONDARY) _____ (Duration) _____ yrs.

(Signed) _____ (Duration) _____ yrs.
 _____ (Address) _____ 191____

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or Ho-
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUT
 RECENT RESIDENTS) _____
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mo.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ **DATE OF** _____

UNDERTAKER _____ **ADDRESS** _____

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

PLACE OF DEATH

County Gentry
Township Cooper
Village _____
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 310 File No. _____
Primary Registration District No. _____ Registered No. 33

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

FULL NAME

Elizabeth Talung

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 12, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,

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) _____

Pneumonia
of 6

BIRTHPLACE (City or town, State or country) _____
FA _____

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

NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signed) A. H. Hooper M.D.
Feb 13 1915 (Address) Dorchester 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.

THE ABOVE (Informant) _____
(Informant) _____ (ADDRESS) _____

Where was disease contracted If not at place of death? _____
Former or usual residence _____

FILED 116 1915
R. Shelby REGISTRAR

PLACE OF BURIAL OR REMOVAL Long Branch DATE OF BURIAL Feb 17 1915
UNDERTAKER W. H. Miller ADDRESS Dorchester Mo

file, date _____ 1915 All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

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.)