PLACE OF DEATH

County Hickory

Township Montgomery
or
Village
or
City (NO. St.: Ward)

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

Registration District No. 363 File No. 8351

Primary Registration District No. 5308 Registered No.

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

FULL NAME Sarah Miller

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

DATE OF BIRTH March 21st 1837 (Month) (Day) (Year)

AGE 77 yrs. 11 mos. 21 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

NAME OF FATHER Geoder Unk

BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know

MAIDEN NAME OF MOTHER Susie Weaver

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benj Liber

(ADDRESS) Gerster Mo

Filed Mar 13th 1915 M L Brewer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar. 12th, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 7th, 1915, to Mar. 12th, 1915, that I last saw her alive on Mar. 12th, 1915, and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

108

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) 8 yrs. mos. 7 ds.

(Signed) J. W. Murray M. D.

Mar 13th, 1915 (Address) Quincy 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 Gerster Graveyard

DATE OF BURIAL Mar 14th 1915

UNDERTAKER H F B Amrine

ADDRESS Quincy Mo

MISSOURI STATE BOARD O
BUREAU OF VITAL STATI
CERTIFICATE OF DEATH

Revised

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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of

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, I _____
(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)

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 _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month)

I HEREBY CERTIFY, that I attende
_____, 191____, to _____
that I last saw h____ alive on _____
and that death occurred, on the date stated al
The CAUSE OF DEATH* was as follows:

_____
_____
_____
_____ (Duration) _____ yrs. _____

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

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths fr
(1) Means of Injury; and (2) whether Accidental, Suicidal, o

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITU
RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yr
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DA

UNDERTAKER | AD

PLACE OF DEATH
Pickens
Mont

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

Registration District No. 363 File No.

Primary Registration District No. 5508 Registered No.

(No. St.: Ward)

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

FULL NAME Sarah Miller

PERSONAL AND STATISTICAL PARTICULARS

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

TE OF BIRTH
(Month) (Day) (Year)

Satisfactory Information Supplied.

E
yrs. mos. ds.

If LESS than 1 day, hrs. or min.

UPATION
rade, profession, or
icular kind of work

General nature of industry,
ness, or establishment in
h employed (or employer)

THPLACE
or town,
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)

BOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

ant)

DDRESS)

1/3, 1915 McL Brust
REGISTRAR.

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied, 191, to , 191, that I last saw h alive on , 191, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

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

(Signed) J. W. Murray M. D.
3/13, 1915 (Address) Quincy, 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

Satisfactory Information Supplied

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gerber Graveyard	Mar 14, 1915
UNDERTAKER	ADDRESS
H B Amrine	Quincy Mo

SUPPLEMENTARY

e, date MAR - 1915 19 All information called for must be written on this Supplementary Certificate.

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 *septichaemia*," "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.)