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 Iron

Township Iron
or
Village Graniteville
or
City — (NO. _____ St.: _____ Ward)

Registration District No. 1159 File No. 8423

Primary Registration District No. 5549 Registered No. 53

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

FULL NAME Agnes Slade

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Female | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH July 30th (Month) 1910 (Day) (Year)

AGE 4 yrs. 7 mos. 21 ds. | If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None 107A
(b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE (City or town, State or foreign country) Flat River Mo

PARENTS
NAME OF FATHER John Slade
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee Sandredge Sumner Co
MAIDEN NAME OF MOTHER Mamie Ruple
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Graniteville Iron Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Slade

(ADDRESS) Graniteville

Filed March 26th 1915 S E Buford REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH March 21st (Month) (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from March 19, 1915, to March 21, 1915, that I last saw her alive on March 19, 1915, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia in right lung

(Duration) 0 yrs. 0 mos. 21 ds.

Contributory (SECONDARY) none

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Dr. Ira A. Manhare M. D.

March 24, 1915 (Address) Ironton 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 _____, 191__

UNDERTAKER | ADDRESS

# 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 *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.)

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

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

**PLACE OF DEATH**

County Iron

Township Iron

or

Village

or

City (NO. St.; Ward)

Registration District No. 1159

Primary Registration District No. 5549

File No.

Registered No. 53

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

**FULL NAME** Agnes Slade

**PERSONAL AND STATISTICAL PARTICULARS.**

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

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)

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) John Slade

(ADDRESS) Graniteville Mo

Filed Mar 22, 1915 S. E. Buford REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Mch 21, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 18th, 1915, to March 21, 1915, that I last saw her alive on March 18, 1915, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 21 ds.

Contributory (SECONDARY) —

(Duration) yrs. mos. ds.

(Signed) Dr. Ira A. Marshall M. D.

Ironton, 1915 (Address) Ironton 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 Middlebrook Mo

DATE OF BURIAL 3-22d, 1915

UNDERTAKER none

ADDRESS —

Original file, date, 19

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

SUPPLEMENTARY

Satisfactory Information Supplied

# Revised United States Standard Certificate of Death

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

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