

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH			
County	Johnson		Registration District No.	429	File No.	9039
Township or Village	Washington		Primary Registration District No.	4255	Registered No.	9
City	Knob Noster (NO. _____)		St.	_____	Ward	_____
FULL NAME			Frances Lettie Davis			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If enter the word)	DATE OF DEATH			
Female	white	married	March 5, 1915 (Month) (Day) (Year)			
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from			
Aug 27, 1894 (Month) (Day) (Year)			Sept. 1st, 1914, to Mar 3, 1915,			
AGE			that I last saw her alive on Mar. 3rd, 1915,			
20 yrs. 6 mos. 5 ds.			and that death occurred, on the date stated above, at 2:30 p.m.			
OCCUPATION			The CAUSE OF DEATH* was as follows:			
(a) Trade, profession, or particular kind of work			Tuberculosis			
(b) General nature of industry, business, or establishment in which employed (or employer)			Pulmonary			
BIRTHPLACE			Contributory			
(City or town, State or foreign country)			X			
Knob Noster Mo			(Duration) _____ yrs. _____ mos. _____ ds.			
PARENTS	NAME OF FATHER		(Signed) _____ M. D.			
	BIRTHPLACE OF FATHER		Mar 3, 1915 (Address) Knob Noster			
	MAIDEN NAME OF MOTHER		* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
	BIRTHPLACE OF MOTHER		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
Geo. Kain		Arkansas		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
Hankens		Mo		Where was disease contracted if not at place of death? _____		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Former or usual residence _____			
(Informant) Mr Geo Kain			PLACE OF BURIAL OR REMOVAL			
(ADDRESS) Knob Noster Mo			Knob Noster			
Filed _____ 191_____			DATE OF BURIAL			
REGISTRAR			3/6 1915			
			UNDERTAKER			
			C. F. Sauls			
			ADDRESS			
			Knob Noster Mo			

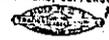
Revised United States Standard Certificate of Death

[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*, *Composer*, *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," "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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County Johnson
Township _____
of _____
Village _____
or _____
City Knoxboro (NO. _____) St. _____ Ward _____

UNTIL THEY ARE COMPLETED BY THE COUNTY STATE BOARD OF HEALTH PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. H 29 File No. _____
Primary Registration District No. H 255 Registered No. 3

FULL NAME

Frances Lettie Davis

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

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)

DATE OF BIRTH Satisfactory Information Supplied
(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 Mar 6 1915 Henry Park

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 / 5 / 1915
(Month) (Day) (Year)

Physician CERTIFY, that I attended deceased from _____ to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows: _____

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 _____

SUPPLEMENTAL CERTIFICATE
Satisfactory Information Supplied

Information called for must be written on this Supplementary Certificate.

Original file, date MAR - 1015 19____

Revised United States Standard Certificate of Death

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

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