

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

1 PLACE OF DEATH  
County Carroll  
Township Washington Registration District No. 449 File No. 9089  
or Russell Primary Registration District No. 5292 Registered No. 896  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME Lattie Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married  
6 DATE OF BIRTH June 11 1890  
(Month) (Day) (Year)  
7 AGE 24 yrs. 8 mos. 6 da. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Carroll Co Mo

PARENTS  
10 NAME OF FATHER J W Scott  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky  
12 MAIDEN NAME OF MOTHER Mary Campbell  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J W Scott  
(Address) Lebanon Mo

15 Filed Mar 2 1915 J M Bellamy  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 17 1915  
(Month) (Day) (Year)  
17 I HEREBY CERTIFY, that I attended deceased from 2-9-15 1915 to 2-17 1915, that I last saw her alive on 2-16 1915, and that death occurred, on the date stated above, at 5 A m.  
The CAUSE OF DEATH\* was as follows:

Burn of lower extremities & thighs

18 (Duration) 9 yrs. 9 mos. 9 ds.  
CONTRIBUTORY (Secondary) J W Prudney  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J W Prudney M. D.  
12-19-15 (Address) Carroll Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
18 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 \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL New Hof Cemetery DATE OF BURIAL 2-20 1915  
20 UNDERTAKER B E Palmer ADDRESS Lebanon Mo

\*Every item of information should be so stated as to show CAUSE OF DEATH.

# 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, 8 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*, *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.)

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

PLACE OF DEATH

County Laclede  
 Township Washington  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_

Registration District No. H49 File No. \_\_\_\_\_  
 Primary Registration District No. 5692 Registered No. 376  
 St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME Lottie Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb. 17 1915  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ 191\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

and that death occurred, on the date stated above, \_\_\_\_\_ 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) \_\_\_\_\_

Burn of lower Extremities & Hips. Clothing caught fire from stove accidentally  
(Duration) yrs. mos. ds.

BIRTHPLACE  
 (City or town, State or foreign country) \_\_\_\_\_

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

NAME OF FATHER \_\_\_\_\_

(Signed) J. W. [Signature] M. D.  
2/18/15 (Address) Old Mo.

BIRTHPLACE OF FATHER  
 (City or town, State or foreign country) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER \_\_\_\_\_

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mo. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_

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

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_  
 PLACE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

REGISTRAR \_\_\_\_\_

MAR -- 1915

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

Original file, date \_\_\_\_\_ 191\_\_\_\_

1. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY Satisfactory Information Supplied.

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