

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

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 Pettis  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Sedalia (NO. \_\_\_\_\_) (Year \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 668 File No. 9668  
Primary Registration District No. 3052 Registered No. 86

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

FULL NAME Jane Delaplain Wilson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 17, 1880  
(Month) (Day) (Year)

AGE 84 yrs. 8 mos. 13 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Oh Home  
(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 Joshua Delaplain  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio  
MAIDEN NAME OF MOTHER Not Known  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) C. Wilson

(ADDRESS) Sedalia Mo.

Filed mar 30 1915 A. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 30, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 20, 1915, to Mar 30, 1915, that I last saw h. alive on Mar 30, 1915, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH\* was as follows:

Pneumonia, lobar  
108  
131 (Duration) yrs. mos. 10 ds.  
Contributory Nephritis  
(SECONDARY) (Duration) yrs. mos. ds.  
8 (Signed) J. P. Dyer M. D.  
Mar 30, 1915 (Address) Sedalia 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 Edina Mo DATE OF BURIAL \_\_\_\_\_ 1915  
UNDERTAKER J. P. Dyer ADDRESS Sedalia Mo

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

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

St. \_\_\_\_\_ Ward \_\_\_\_\_

**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

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

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, 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) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Address) \_\_\_\_\_ M. D.

\*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) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

LINK—THIS IS A PUBLIC RECORD  
 fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state  
 may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

Pettis

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

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

County

Township

Registration District No. 668

File No.

Village

Primary Registration District No. 3032

Registered No. 86

City

Sedalia

(NO. FULL NAME) Jam. D. Wilson

St. Ward

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

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE u MARRIED WIDOWED OR DIVORCED (Write the word)DATE OF DEATH May 30, 1915  
(Month) (Day) (Year)DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Month) (Day) (Year)HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,  
and that death occurred, on the date stated above, at 10 m.

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

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 Lobar  
92  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Contributory Chronic Nephritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) D. D. Dye M. D.  
3/30, 1915 (Address) \_\_\_\_\_

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

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) \_\_\_\_\_

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

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

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

Filed 3/30, 1915 A. B. Lopez REGISTRAR

Original file, date \_\_\_\_\_, 19\_\_\_\_ All information called for must be written on this Supplementary Certificate.

UNREAD  
N. B.—Every item of information should be carefully supplied. PAGE #  
CAUSE OF DEATH in plain terms, so that it may be properly classified.Satisfactory information supplied.  
SUPPLEMENTARY  
Information supplied.

# Revised United States Standard Certificate of Death

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

8996

**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.)