

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

PLACE OF DEATH
County St. Clair

Township _____
or
Village _____
or
City Roscoe (NO. _____)

Registration District No. 766
Primary Registration District No. 4461

File No. 9907
Registered No. 1

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

FULL NAME Ethel Mabel Carter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH Feb 23, 1915, to Mar 2, 1915
(Month) (Day) (Year)

DATE OF BIRTH Oct 17, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 23, 1915, to Mar 2, 1915, that I last saw her alive on Mar 2, 1915, and that death occurred, on the date stated above, at 4:10 p.m.

AGE 1 yrs. 4 mos. 13 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:
Pneumonia

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

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(Duration) ____ yrs. ____ mos. 7 ds.

BIRTHPLACE (City or town, State or foreign country) Roscoe Mo

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

NAME OF FATHER John W. Carter

(Signed) C. S. Stratton M. D. Mar 3, 1915 (Address) Roscoe Mo

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

*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 Mabel Melton

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

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

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. W. Carter

Where was disease contracted if not at place of death? _____

(ADDRESS) Roscoe Mo

Former or usual residence _____

Filed Mar 3, 1915, C. S. Stratton REGISTRAR

PLACE OF BURIAL OR REMOVAL Roscoe Cemetery DATE OF BURIAL Mar 3, 1915

UNDERTAKER A. Terrel ADDRESS Roscoe Mo

N. H. - Every statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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*, *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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
St. Clair
County _____
Township _____
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. *766* File No. _____
Primary Registration District No. *4461* Registered No. *1*

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

FULL NAME *Ethel Mabel Carter*

PERSONAL AND STATISTICAL PARTICULARS

SEX *F* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED *S*
(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) _____

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 *3/3* 191*5* *C. S. Stratton*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Feb 21* 191*5*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, and that death occurred, on the date stated above, at _____.

Supplementary Information Supplied. _____
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

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

(Signed) *C. S. Stratton* M. D.
3/3 191*5* (Address) *Roscoe 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 disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

MAR 1915

Original file, date _____

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

Revised United States Standard Certificate of Death

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

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