

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

PLACE OF DEATH

County Saline  
Township Marshall  
or  
Village  
or  
City Marshall (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 796  
Primary Registration District No. 3038

File No. 11146  
Registered No. 772

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

FULL NAME

Bettie Newton

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH July 25, 1862 (Month) (Day) (Year)  
AGE 52 yrs. 7 mos. 19 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Arrow Rock Saline Co., Mo.

NAME OF FATHER Joseph Newton

BIRTHPLACE OF FATHER (City or town, State or foreign country) Near Arrow Rock Saline Co., Mo.

MAIDEN NAME OF MOTHER Mary Catherine Smith

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henry County Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Newton  
(ADDRESS) Marshall Mo.

Filed Mar 15, 1915 T. Manning REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 14, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 20, 1899 to March 14, 1915, that I last saw her alive on March 14, 1915,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:  
Fall from epileptic seizure

183 (Duration) 25 yrs. 6 mos. 19 ds.

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

(Signed) John R. Kree M. D. (Address) Marshall

\*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 Ridge Park DATE OF BURIAL Mar 16 1915

UNDERTAKER B. M. Walker ADDRESS Marshall Mo.

N. B. - Every item of information 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.

# 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*, *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

*Saline*

County

Township

Village

City

*Marshall*

Registration District No.

*796*

File No.

Primary Registration District No.

*3038*

Registered No.

*22*

FULL NAME

*Bettie Huston*

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX  
*M*

COLOR OR RACE  
*W*

SINGLE MARRIED WIDOWED OR DIVORCED  
*S*

DATE OF DEATH

*Feb 14*, 19*15*  
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

If LESS than 1 day, hrs. or mins. mos. ds.

I HEREBY CERTIFY, that I attended deceased from *Saline, Mo.*, 191*5*, to *Saline, Mo.*, 191*5*, that I last saw h. *alive on* *70*, 191*5*, and that death occurred, on the date stated above, at *70* m.

The CAUSE OF DEATH\* was as follows:  
*Fall from Epileptic seizure into a bathtub, probably drowning*

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)

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *John R. Hall* M.D.  
*3/15*, 191*5* (Address) *Marshall*

\*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

*3/15*, 191*5* *J. Manning*

REGISTRAR

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Original file, date

*Mar 15*, 191*5*

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

STATE OF DEATH should be certified. If properly classified. If omitted, AGE, should be properly classified. If omitted, OCCUPATION is very important.

Satisfactory Information Supplied. SUPPLEMENTARY INFORMATION Supplied.

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