

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

11664

1 PLACE OF DEATH  
County Buchanan

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_

Registration District No. 85

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

City St. Joseph

Primary Registration District No. 1001 Registered No. 384

(No. 502 So 15<sup>th</sup> St. \_\_\_\_\_ Ward)

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

2 FULL NAME Elizabeth B Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widow  
(If write the word)

6 DATE OF BIRTH July 18<sup>th</sup> 1829  
(Month) (Day) (Year)

7 AGE 85 yrs 8 mos 25 ds If LESS than 1 day, \_\_\_\_\_ hrs, or \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed (or employer) 52

9 BIRTHPLACE (City or town, State or foreign country) Kentucky 87B

PARENTS 10 NAME OF FATHER Nathaniel Herndon 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky 12 MAIDEN NAME OF MOTHER Lucinda Robinson 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Samuel S. Skull (Address) 502 So. 15<sup>th</sup>

15 Filed April 13 1915 5816 Harrington Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13<sup>th</sup> 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 13<sup>th</sup> 1915, to April 13<sup>th</sup> 1915, that I last saw her alive on March 12<sup>th</sup> 1915, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH\* was as follows:  
Paralysis agitans  
(Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) Burns (X-Ray)  
(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Dr. D. M. D. April 13, 1915 (Address) St. Joseph, 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 St. Mora Cemetery DATE OF BURIAL Apr. 14, 1915

20 UNDERTAKER W. Meierhoffer ADDRESS 824 Felix St.

# 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.)

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

PLACE OF DEATH Buchanan  
County Buchanan  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

Registration District No. 85 File No. \_\_\_\_\_  
Primary Registration District No. 1001 Registered No. 384

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

FULL NAME Elizabeth B. Baker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OF RACE W. SINGLE W. MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
(# fills the word)

DATE OF DEATH \_\_\_\_\_, 1915  
(Month) (Day) (Year)

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

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

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

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

Paralytic typhus  
Epithelioma of face  
(Duration) 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Contributory Paralytic typhus  
(SECONDARY) Epithelioma of face  
(Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) Indennore M. D.  
June 15, 1915 (Address) St. Joseph, 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) \_\_\_\_\_

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted, if not at place of death? \_\_\_\_\_

(Informant) \_\_\_\_\_

Former or usual residence \_\_\_\_\_

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

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

Filed June 17, 1915 W. H. Harrington REGISTRAR

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

SUPPLEMENTARY

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

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