

## PLACE OF DEATH

County Cole

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Jefferson (NO. \_\_\_\_\_)Registration District No. 213-File No. 12025Primary Registration District No. 3014-Registered No. 72-FULL NAME Ester Short

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

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Colored SINGLE Single MARRIED WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH May (Month) 1915 (Year) (Day) 16AGE 11 yrs. 11 mos. 11 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) Jefferson CityNAME OF FATHER Stone SweeneyBIRTHPLACE OF FATHER (City or town, State or foreign country) Jeff CityMAIDEN NAME OF MOTHER Ethel ShortBIRTHPLACE OF MOTHER (City or town, State or foreign country) Cole co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edd Young(ADDRESS) 403 State StFiled Apr. 19- 1965 W. B. Wood REGISTRARMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 16, 1965 (Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from about March 5, 1965, to April 15, 1965, that I last saw her alive on April 15, 1965, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar  
23A  
105Contributory T.B. (Duration) 17 yrs. 17 mos. 17 ds.(Signed) O. E. Amos M. D. (Address) 327<sup>00</sup> High

\*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

DATE OF BURIAL 4/17/65 1965

UNDERTAKER

ADDRESS Jeff City Mo

WRITING IN ERASING 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.

# 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, 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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, 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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Cole

Township \_\_\_\_\_

or

Village \_\_\_\_\_

City Jefferson City (NO. \_\_\_\_\_)

Registration District No. 213

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

Primary Registration District No. 3014

Registered No. 72

FULL NAME

Ester Short

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED S  
(Write the word)

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

AGE \_\_\_\_\_  
it \_\_\_\_\_ 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 (if 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 4/19 1915 W. P. Keenan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 16, 1915  
(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:

Pneumonia Lobar  
95

Contributory Tuberculosis Pulmonary  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. 2 mos. \_\_\_\_\_ ds.

(Signed) A. E. Anso M. D.  
4117, 1915 (Address)

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1915

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

Original file, date Apr 15 1915 information called for must be written on this Supplementary Certificate.

MARGIN RESERVY INK--THIS IS A PERMAX

RE PR. INLY. WITH U

Every item of info. CAUSE OF DEATH I. Be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

Satisfactory Information Supplied.  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.  
Satisfactory Information Supplied.

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Association]

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