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

12094

PLACE OF DEATH

County: Dawess

Township: Grand River — Registration District No. 251 — File No.

or

Village: — Primary Registration District No. 5350 — Registered No.

or

City: (NO. St.: Ward)

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

FULL NAME Sarah Elizabeth Chamberlain

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

DATE OF BIRTH: January 2nd (Month) (Day), 1822 (Year)

AGE: 93 yrs. 3 mos. 0 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Springfield Ills

PARENTS
NAME OF FATHER: Chas Boyd
BIRTHPLACE OF FATHER (City or town, State or foreign country): N-Y-
MAIDEN NAME OF MOTHER: Eliza Dixson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C S Chamberlain

(ADDRESS): Gallatin Mo

Filed Apr 2, 1915 — N. M. Hetzel, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 1 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1914, to April 14, 1914, that I last saw h~~er~~ alive on Apr. 14, 1914, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(Duration) 1 yrs. 3 mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. V. Thompson M. D.

Apr. 2 1915 (Address) Gallatin 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: Bethel Cemetery — DATE OF BURIAL: Apr. 2, 1915

UNDERTAKER: John O. Buren — ADDRESS: Jamesport Mo

N. B.—Every item of information should be carefully supplied; [illegible] be stated EXACTLY. PHYSICIA[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

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

PLACE OF DEATH

County: Daviess

Township: Grand River

or Village: _____

or City: _____ (NO. _____ St.: _____ Ward)

Registration District No.: 251

File No.: _____

Primary Registration District No.: 5350

Registered No.: _____

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

FULL NAME Sarah Elizabeth Chamberlain

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W.

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): W.

DATE OF BIRTH: Satisfactory Information Supplied. (Month) _____ (Day) _____, 1 (Year)

AGE: _____ yrs. _____ mos. 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) Satisfactory Information Supplied.

(ADDRESS) _____

Filed July 3, 1915. F. M. Retzel, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr. 1, 191 51 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied., 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: Satisfactory Information Supplied.

Osteomyelitis of Molar Bone of right side

(Duration) 1 yrs. _____ mos. _____ ds.

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

(Signed) F. V. Nave M.D. M.D.

Apr. 2, 191 5 (Address) Gallatin 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? Satisfactory Information Supplied.

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: _____ DATE OF BURIAL: _____, 191__

UNDERTAKER: John O. Buren ADDRESS: Jamesport

SUPPLEMENTARY

Original file, date _____, 19__ 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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