

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

PLACE OF DEATH
County Clay
Township Clay
or
Village
or
City (NO. St. Ward)

Registration District No. 287 File No. 12163
Primary Registration District No. 54050 Registered No. 17

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

FULL NAME Amandy Rose

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Fe Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
DATE OF BIRTH 2 25 1890
(Month) (Day) (Year)
AGE 25 yrs. 1 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
BIRTHPLACE (City or town, State or foreign country) Mo.

DATE OF DEATH April 9th, 1915
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from April 4, 1915, to April 9, 1915, that I last saw her alive on April 9, 1915, and that death occurred, on the date stated above, at 9³⁰ a.m.

The CAUSE OF DEATH* was as follows:
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Septicemia

PARENTS
NAME OF FATHER Bin Vardell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn
MAIDEN NAME OF MOTHER Amandy Horner
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Septicemia
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. H. Lamborgh M. D.
4/10 1915 (Address) Hornersville 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Rose

PLACE OF BURIAL OR REMOVAL Hornersville DATE OF BURIAL 4/10 1915

(ADDRESS) Hornersville, Mo.

UNDERTAKER T. F. Kinsoving ADDRESS Hornersville Mo

Filed Apr 10 1915 E. J. Cooper REGISTRAR

No. of days 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, 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, peritoneum*, 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.)

PHYSICIANS should file this statement of OCCUPATION in very important terms, so that it may be properly classified.

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

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

County Franklin Registration District No. 287 File No. _____
Township Clay or _____ Primary Registration District No. 3405-a Registered No. 17
Village _____ or _____ City _____ (NO. _____ St.: _____ Ward _____)

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

FULL NAME Amanda Rose

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF FACE N. SINGLE M. MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH _____, 1 (Year) _____ (Month) _____ (Day)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ 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 H-10 1915 C. G. Cope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1915 (Month) Apr. (Day) 9 (Year)

HEREBY CERTIFY that I attended deceased from _____, 1915, to _____, 1915, that I last saw h. satisfactory alive on _____, 1915, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: Septicemia

Renal Thrombosis following Abortion

Contributory Septicemia (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) L. H. Lugebaugh M.D. 4-10-15 (Address) Hornersville

*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 _____

UNDERTAKER J. F. Kussalouy ADDRESS Hornersville

SUPPLEMENTARY Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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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.)