

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

PLACE OF DEATH

County Shelby

Township _____

Village Shelbyville

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 831

Primary Registration District No. 4504

File No. 15038

Registered No. 7

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

FULL NAME Lupine Danrell

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH April 22, 1915
(Month) (Day) (Year)

DATE OF BIRTH June 21, 1839
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 26, 1915, to April 22, 1915, that I last saw her alive on April 22, 1915, and that death occurred, on the date stated above, at 12-50 AM.

AGE 75 yrs. 10 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Uremic Coma
1915

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

BIRTHPLACE (City or town, State or foreign country) Paris MO.

Contributory Interstitial Nephritis
(SECONDARY) (Duration) ___ yrs. ___ mos. 10 ds.

PARENTS NAME OF FATHER Oliver Stribling BIRTHPLACE OF FATHER Ky. MAIDEN NAME OF MOTHER Jane Boggs BIRTHPLACE OF MOTHER Paris

(Signed) C. E. Salzer M. D. 4123 1915 (Address) Shelbyville MO.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Loretta Sanders (ADDRESS) Shelbyville 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 _____

Filed April 22 1915 W. Carson REGISTRAR

PLACE OF BURIAL OR REMOVAL Shelbyville, D. C. Place DATE OF BURIAL Apr. 23, 1915
UNDERTAKER J. H. Thompson Son ADDRESS Shelbyville, Mo.

Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
 COLOR OR RACE _____
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (If wife the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ yrs. _____ 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 (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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed _____ 191____
 REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceased

that I last saw h. _____ alive on _____, 191____, to _____, 191____.

and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

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

Contributory

(SECONDARY)

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

(Signed)

(Address)

M. D.

*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 actual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191____

UNDERTAKER

ADDRESS

Applied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important

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.

PLACE OF DEATH
Shelby

County *Shelby*

Township _____

Village _____

City *Shelbyville* (NO. _____)

Registration District No. *831*

File No. _____

Primary Registration District No. *4504*

Registered No. *7*

FULL NAME *Lupine Deauney*

[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 *W*
(Write the word)

DATE OF DEATH *Apr 22*, 191*5*
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____
Satisfactory Information Supplied, to _____, 191____
that I last saw h_____ alive on _____, 191____
and that death occurred, on the date stated above, at *12:50* m.

AGE _____
IF LESS than 1 day, _____ hrs. or _____ min.
_____ yrs. _____ mos. _____ ds.

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) _____

Urnaeus Coma
(Duration) _____ yrs. _____ mos. *10* ds.

BIRTHPLACE (City or town, State or foreign country) _____

Contributory *Intermittent febrile*
(Duration) *8* yrs. _____ mos. _____ ds.
(Signed) *Bo Galvan* M. D.
4/23 1915 (Address) *Shelbyville, Mo*

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) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) _____

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) _____

Where was disease contracted if not at place of death? _____

Filed *4/22* 191*5* *John Loacon*

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____

REGISTRAR

Original file, date *Apr* 191*5* information called for must be written on this Supplementary Certificate.

could be stated EXACTLY. PHYSICIANS should state exact statement of cause of death. EXACT STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Supplementary Information Supplied

Supplementary Information Supplied

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) *Colton 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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