

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

1 PLACE OF DEATH  
County Jay  
Township River  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. 1032 File No. 15114  
Primary Registration District No. 6144 Registered No. 2

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

2 FULL NAME Margaret A. Kastor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH November 6 1842  
(Month) (Day) (Year)

7 AGE 72 yrs. 5 mos. 29 ds. IF LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Pa.

PARENTS  
10 NAME OF FATHER Wm - Armour  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa.  
12 MAIDEN NAME OF MOTHER Elizabeth Armour  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) H. B. Kastor  
(Address) Willow Springs, Mo.

15 Filed April 4, 1915 - F. M. Fleming  
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 29, 1915 to Apr 3, 1915 that I last saw her alive on Mar. 26, 1915 and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH\* was as follows:  
Organic Heart disease  
99 A  
95 B  
(Duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary)  
(Signed) J. B. Davis M. D.  
473 1915 Willow Spgs. Mo.  
(Address)

\*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 Thunder Country DATE OF BURIAL 4-4, 1915

20 UNDERTAKER E. M. Rollins Willow Spgs. Mo. ADDRESS

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

# 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*, *Sarcoma*, etc., of ..... (name organ; "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 state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

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 Lucas  
Township Peru  
or  
Village  
or  
City

Registration District No. 1037 File No. \_\_\_\_\_

Primary Registration District No. 6144 Registered No. 3

(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Margaret A Koster

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M  
(Write the word)

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

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

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 4/4 1915

REGISTRAR \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 3, 1915  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 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:  
Organic Heart Dis  
Mitral Insufficiency  
99 sent home  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J B Davis M. D.  
4/3 1915 (Address) Willow Spring

\*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 \_\_\_\_\_ 191\_\_\_\_

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

Supplementary Information Supplied

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