

PLACE OF DEATH

County Wayne
 Township 28 Jefferson Registration District No. 1020 File No. 15166
 or
 Village McGehee Primary Registration District No. 6190 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 Archie Whitworth

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widowed</u>
DATE OF BIRTH <u>6</u> / <u>1</u> / <u>1891</u> (Month) (Day) (Year)		
AGE <u>73</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Calasaway Co Mo</u>		
PARENTS	NAME OF FATHER <u>Nathan Todd</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not United States</u>	
	MAIDEN NAME OF MOTHER <u>Not known</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Kievelley

(ADDRESS) McGehee

Filed April 4 1915

R. B. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 3rd, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 29, 1915, to April 3, 1915, that I last saw her alive on April 3, 1915, and that death occurred, on the date stated above, at 11:30 am.

The CAUSE OF DEATH* was as follows:

La grippe complicated with Tuberculosis

(Duration) 5 yrs. 0 mos. 0 ds.

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

(Signed) Irvin P. Barrows M. D. 4/3, 1915 (Address) McGehee 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

Houghman Cem 4 & 4, 1915

UNDERTAKER

Ed Walk

DATE OF BURIAL

ADDRESS

McGehee

FADING INK—THIS IS A PHOTOGRAPHIC RECORD

N. B.—Physicians should state the occupation of the deceased. 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*, *peritonaeum*, 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.)



WRITE PLAINLY, WITH UNIFORMITY. THIS IS AN IRMANYEN NT RECORD

PHYSICIANS should state the OCCUPATION, if any, of the deceased. Exact statement is very important.

PLACE OF DEATH

County Wayne
Township Jefferson
or
Village
or
City

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

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

Registration District No. 1020 File No. _____
Primary Registration District No. 6190 Registered No. _____
(NO. _____ St. _____ Ward)

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

FULL NAME Annice Philworth

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(If fills the word)

DATE OF BIRTH _____, 191____
(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)

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 May 5 1915 J.B. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

CAUSE OF DEATH* was as follows:
La Grippe Complicated with Tuberculosis of Lung
(Duration) _____ yrs. _____ mos. _____ ds. 5 days

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Wm P. Barnes M.D.
June 1915 (Address) an e ge

*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 STATE OF BURIAL

UNDERTAKER ADDRESS

Original file, date _____ 191____ information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY INFORMATION supplied.

Information supplied

Revised United States Standard Certificate of Death

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

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