

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

15813

1 PLACE OF DEATH
County Wasson
Township Canaan
Village
City (NO. St. Ward)

Registration District No. 305
Primary Registration District No. 5423

File No.
Registered No. 15

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

2 FULL NAME Anna E. Vaughan

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 October 26 1888
(Month) (Day) (Year)

7 AGE 66 yrs. 6 mos. 5 ds.
If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE Kentucky
(City or town, State or foreign country)

PARENTS
10 NAME OF FATHER Jessie Brewitt
11 BIRTHPLACE OF FATHER Kentucky
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Wm Susanna
13 BIRTHPLACE OF MOTHER Kentucky
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmet Vaughan
(Address) Wrensville, Mo

15 Filed May 8 1915 J. P. Ferrell
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 1 1915 to May 1 1915; that I last saw him alive on May 1 1915; and that death occurred, on the date stated above, at 10:35 P.M.

The CAUSE OF DEATH* was as follows:
Unknown
(Had spinal curvature, fractured hip & pain that appeared to be rheumatoid in origin)
18 (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) fractured hip & spinal curve
(Duration) 4 yrs. mos. ds.

(Signed) N. G. Matthews M. D.
May 3 1915 (Address) Wrensville, Mo.

*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 Leach Cemetery, Wrensville
DATE OF BURIAL May 3 1915

20 UNDERTAKER Herman Koch
ADDRESS Wrensville, Mo

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.)

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

1 PLACE OF DEATH

County Gasconade
Township Carson
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 305 File No. _____
Primary Registration District No. 5433 Registered No. 15

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

2 FULL NAME

Anna E. Naughey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED M
(Write the word)

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

7 AGE _____
If LESS than 1 day, hrs. or min.?
yrs. mos. ds.

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

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

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

15 Filed May 8 1915
J. Ferrrell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____, and that death occurred, on the date stated above, at 10:38 p.m.

The CAUSE OF DEATH* was as follows:
Unknown
Had special Curator, husband
Had a fall that appeared to be the
cause of death
fractured hip & spinal trouble
fracture caused by the fall.

(Signed) _____ M. D.
May 3 1915 (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 _____ DATE OF BURIAL _____, 191____

20 UNDERTAKER _____ ADDRESS _____

N. B.—Every fee to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state fact statement of OCCUPATION is very important.

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

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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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), 29ds.; *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.)

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