

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item 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.

1 PLACE OF DEATH.

County Taney

Township Minicy Scott

Inc. Town _____

City _____

Registration District No. 860

Primary Registration District No. 6129

(No. _____ St.; _____ Ward)

Missouri
STATE OF ~~MISSOURI~~
STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

23816

File No. _____

Registered No. 117

2 FULL NAME Caroline Randolph

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)
6. DATE OF BIRTH <u>October</u> <u>8th</u> <u>1845</u> Month Day Year		
7. AGE <u>69</u> yrs. <u>7</u> mos. <u>1</u> ds.		If LESS than 1 day, _____ hrs. or _____ min?
8. OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9. BIRTHPLACE (State or Country) <u>Sweden</u>		
PARENTS	10. NAME OF FATHER <u>Wm. West</u>	
	11. BIRTHPLACE OF FATHER (State or Country) <u>Sweden</u>	
	12. MAIDEN NAME OF MOTHER <u>unknown</u>	
13. BIRTHPLACE OF MOTHER (State or Country) <u>Sweden</u>		

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lula Callen

(Address) Minicy

15.

Filed July 1 1915

R. B. Kitz
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1915
Month Day Year

17. I HEREBY CERTIFY That I attended the deceased from 5-7- 1915, to 5-9- 1915, that I last saw her alive on 5-9- 1915 and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH * was as follows:

congestion
58 OK

Duration yrs. mos. 1/2 ds.

Contributory SECONDARY

Duration yrs. mos. ds.

Signed T. M. Callen M. D.
5-9- 1915 Address Denver, Ark.

*State the DISEASE CAUSING DEATH, or, in death 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. 2 mos. ds. State 19 yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence Hilda Mo

19. PLACE OF BURIAL OR REMOVAL

Brown cemetery

DATE OF REMOVAL

May 11, 1915

20. UNDERTAKER

ADDRESS

1 PLACE OF DEATH .

County _____
 Township _____
 Inc. Town _____
 City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 (No. _____ St.; _____ Ward) _____
 If death occurred in hospital or institution give its NAME and address of street and number _____

2 FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____
 4. COLOR OR RACE _____
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____
 6. DATE OF BIRTH _____
 _____ Month _____ Day _____ Year _____
 7. AGE _____ yrs. _____ mos. _____ dis. _____ min? _____
 If LESS than 1 day, _____ hrs. or _____ min?
 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 (State or Country) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (State or Country) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (State or Country) _____

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

(Address) _____

15. Filed _____ 191 _____

REGISTRAR

STATE OF ARKANSAS
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH _____
 _____ Month _____ Day _____ 19 _____

17. I HEREBY CERTIFY That I attended the deceased from _____, 191 _____, to _____, 19 _____, that I last saw h _____ alive on _____ and that death occurred on the date stated above, at _____ The CAUSE OF DEATH * was as follows: _____

Contributory _____ yrs. _____ mos. _____
 SECONDARY _____
 Signed _____
 _____, 191 _____ Address _____
 Duration _____ yrs. _____ mos. _____
 Duration _____ yrs. _____ mos. _____

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSE (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDE.
 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) _____
 At Place _____ yrs. _____ mos. _____ ds. _____ In the State _____ yrs. _____ mos. _____
 Where was disease contracted, if not at place of death? _____
 Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL _____ DATE OF REMOVAL _____
 20. UNDERTAKER _____ ADDRESS _____

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item 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.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Linn
Township Scott
or
Village
or
City

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

Registration District No. 860 File No.
Primary Registration District No. 6129 Registered No. 117
(NO. St. Ward)

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

2 FULL NAME Caroline Randolph

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH May 9 1915
(Month) (Day) (Year)

6 DATE OF BIRTH October 8 1884
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 5-9-1915, to 5-9-1915, that I last saw him alive, on 5-9-1915, and that death occurred, on the date stated above, at 5:30 P.M.

7 AGE 69 yrs. 7 mos. 1 ds.
If LESS than 1 day... hrs. or... min.?

The CAUSE OF DEATH* was as follows:

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

congestion
(Duration) yrs. mos. ds.

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

CONTRIBUTORY malaria
(Secondary) (Duration) yrs. mos. ds.

10 NAME OF FATHER Walter

(Signed) S. M. Collier M. D.
5-9-1915 (Address) Denver, Ark.

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

12 MAIDEN NAME OF MOTHER Johnson

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

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death 2 yrs. mos. ds. In the State 19 yrs. mos. ds.
Where was disease contracted if not at place of death? unknown

(Informant) Mrs. Lela Collier
(Address) Miner, Mo.

Former or usual residence Hilda, Mo.

15 Filed 7/1 1915 R. B. Kite Registrar

19 PLACE OF BURIAL OR REMOVAL Brown Care DATE OF BURIAL May 11 1915

20 UNDERTAKER X ADDRESS X

Original file, date 10/1 -- 1915, 19.....

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

91852
23816

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*, *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), 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.)