

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

1 PLACE OF DEATH

County Buchanan

Registration District No. 85

File No. 29832

Township \_\_\_\_\_  
or

Primary Registration District No. 1001

Registered No. 904

Village \_\_\_\_\_  
or

(NO. St. Joseph's Hospital St. \_\_\_\_\_)

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

City St. Joseph

2 FULL NAME Mattie Vance

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

16 DATE OF DEATH

Oct 6 1915  
(Month) (Day) (Year)

6 DATE OF BIRTH

Mich 30 1887  
(Month) (Day) (Yr)

17 I HEREBY CERTIFY, that I attended deceased from October 5 1915 to October 6 1915

7 AGE

136 yrs. 6 mos. 6 ds.

If LESS than 1 day...hrs. or...min.?

that I last saw her alive on October 6 1915 and that death occurred, on the date stated above, at 1 1/2 P.M.

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry business or establishment in which employed (or employer) at home

The CAUSE OF DEATH\* was as follows:  
Abdominal Hysterectomy  
137 139 952  
137 139 952  
137 139 952  
(Duration)..... yrs..... mos..... ds.

9 BIRTHPLACE

(City or town, State or foreign country) Mo

CONTRIBUTORY

(Secondary) \_\_\_\_\_  
(Duration)..... yrs..... mos..... ds.

10 NAME OF FATHER

J. A. Pritchall

11 BIRTHPLACE OF FATHER

Mo.

12 MAIDEN NAME OF MOTHER

Margaret Grindstaff

13 BIRTHPLACE OF MOTHER

North. C. Mo

(Signed) Carroll Otter M. D.  
Oct. 6 1915 (Address) 120 S. 7th. St.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Derank Leance

(Address) Pilmore 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? Pilmore Mo

Former or usual residence Pilmore Mo

15

Filed Oct 7 1915 W. H. Harrington Registrar

19 PLACE OF BURIAL OR REMOVAL

Rosendale Mo

DATE OF BURIAL

Oct 8 1915

20 UNDERTAKER

Horton Beagle Und. Co

ADDRESS

704 So. 8th. St.

B. J. H. Kaylor

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.

# 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 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.)

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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH  
County Buchanan REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW  
Township \_\_\_\_\_ Registration District No. 85 File No. 29832  
or \_\_\_\_\_ Village \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 904  
or \_\_\_\_\_ City St. Joseph (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
2 FULL NAME Mattie Lauce [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED M (Write the word)  
6 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) 1 \_\_\_\_\_ (Year)  
7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ 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 (City or town, State or foreign country) \_\_\_\_\_  
PARENTS  
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) \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 6 1916  
(Month) (Day) (Year)  
17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 1916 to \_\_\_\_\_ 1916 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 1916 and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:  
Abdominal Hysterectomy  
Acetonemia  
Cardiac Insufficiency  
Chronic Nephritis with Protoplasma  
(Duration \_\_\_\_\_ mos. \_\_\_\_\_ ds.)  
CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) W. E. Harrington M. D. 10-6-1916 (Address) 120 So. 7th St.  
\*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 \_\_\_\_\_ 1916  
20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY INFORMATION SUPPLIED

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_  
15 Filed May 11, 1916 W. E. Harrington Registrar

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