

THIS IS A PERMANENT RECORD

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
CERTIFICATE OF DEATH**

PLACE OF DEATH

County No. Jaway
Township White Cloud
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 616 File No. 2646
Primary Registration District No. 3818 Registered No. 12

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

FULL NAME Flores Ellen Hale

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
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DATE OF BIRTH September 18, 1865
(Month) (Day) (Year)

AGE 50 yrs. 3 mos. 6 ds.
If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) New Mexico Ia.

PARENTS	NAME OF FATHER <u>Richard Christ</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Iowa</u>
	MAIDEN NAME OF MOTHER <u>Julia Ann Snellian</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Hale
(ADDRESS) Barnard Mo.

Filed Jan 5, 1916, E. Louis Smit
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 24, 1915
(Month) (Day) (Year)

I, HEREBY CERTIFY, that I attended deceased from April 12, 1915, to Dec. 24, 1915, that I last saw her alive on Dec. 10, 1915, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the breast metastatic after removal
50

(Duration) 2 yrs. ____ mos. ____ ds.

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

(Signed) J. A. Larabee M. D.
Dec 27, 1915 (Address) Barnard 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 Barnard Mo. DATE OF BURIAL Dec 25, 1915

UNDERTAKER Cann ADDRESS Boletow

No. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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

PLACE OF DEATH

County _____
Township _____ or _____
Village _____ or _____
City _____ (NO _____)
Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____
St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
COLOR OR RACE _____
SINGLE _____
MARRIED _____
WIDOWED _____
OR DIVORCED _____
(If wife the word)
DATE OF BIRTH _____ (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)

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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 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:

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

(Address) _____ M. D.

*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. 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 _____

WRITE PLAINLY, WITH UNFADING INK. - THIS IS A PERMANENT RECORD

Every death certificate filed with the Registrar shall be a permanent record. It is the duty of every citizen to see that the information furnished is correct and complete. The Registrar is not responsible for errors in the information furnished.

1 PLACE OF DEATH

County *Stodard*
Township *White Cloud*
Village
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. *616* File No.
Primary Registration District No. *5818* Registered No. *12*

2 FULL NAME *Flora Ellen Hale* (NO. ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W.* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Married*

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE 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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *J. S. Hakea* (Address) *Barnard Mo.*

15 Filed *Feb 29 1916* *E. Lois Smith* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191... (Year) *Dec. 24 1915*

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Address) 191... (Address) *Information Supplied.*

*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 *J. W. Lamm*

Revised United States Standard Certificate of Death

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

2646

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.)