

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

PLACE OF DEATH
County Rolls
Township Saltrim Registration District No. 727 File No. 3001
or
Village
or
City Berry (NO. _____ St. _____ Ward _____)
FULL NAME Esther Hoover West

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

PERSONAL AND STATISTICAL PARTICULARS

SEX woman COLOR OR RACE white SINGLE widow
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH July 3 1839
(Month) (Day) (Year)
AGE 76 yrs. 6 mos. 11 ds.
If LESS than
1 day, ___ hrs.
or ___ min.?
OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

Ind.

PARENTS

NAME OF FATHER

Unknown

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Indiana

MAIDEN NAME OF MOTHER

Esther Hoover

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emmett W. Long

(ADDRESS)

Berry Mo.

Filed

Feb 10th 1916

J. Waller

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 14

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from Dec 14, 1915, to Jan 6, 1916, that I last saw her alive on Jan 6, 1916, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Fracture of hip and Old age.

186A

194E

162

Contributory

(SECONDARY)

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

(Signed)

Jan 15th 1916

R. O. Suter

M. D.

(Address) Berry 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

Green Lawn

DATE OF BURIAL

Jan 16, 1916

UNDERTAKER

ADDRESS

1800 Rock Berry

Mo

N. B.—Every item of information should be carefully supplied. Also, state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

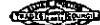
Revised United States Standard Certificate of Death

[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*, *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.)



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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	Ralls		REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW	727
Township	Sattreiver		Registration District No.	5959
or			Primary Registration District No.	5959
Village			St.	Ward
or				
City	No.			
2 FULL NAME			Esther Hoover West	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	16 DATE OF DEATH	
F	W	M	Jan. 14 1916	
6 DATE OF BIRTH			17	
(Month) (Day) (Year)			HEREBY CERTIFY, that I attended deceased from	
7 AGE			that I last saw him alive on	
If LESS than 1 day, hrs. or min.?			and that death occurred, on the date stated above, at	
8 OCCUPATION			The CAUSE OF DEATH* was as follows:	
(a) Trade, profession, or particular kind of work			Fracture of hip and pelvis	
(b) General nature of industry business, or establishment in which employed (or employer)			Old age accidental	
9 BIRTHPLACE			Duration yrs. mos. ds.	
(City or town, State or foreign country)			17 yrs. 2 mos. 20 ds.	
PARENTS	10 NAME OF FATHER		CONTRIBUTORY	
	11 BIRTHPLACE OF FATHER		(Secondary)	
	12 MAIDEN NAME OF MOTHER		(Duration) yrs. mos. ds.	
	13 BIRTHPLACE OF MOTHER		(Signed) 1-15-1916 (Address) Perry St.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
(Informant)			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)	
(Address)			At place of death yrs. mos. ds. In the State yrs. mos. ds.	
15			Where was disease contracted if not at place of death?	
Filed Mch 10 1916 F. Waller Registrar			Former or usual residence	
			19 PLACE OF BURIAL OR REMOVAL	
			DATE OF BURIAL	
			20 UNDERTAKER	
			ADDRESS	

Original file, date, 1916, 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]

100-3001

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