

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.

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

PLACE OF DEATH
County Randolph
Township Salisbury
Village _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 733 File No. 3028
Primary Registration District No. 5967 Registered No. 8

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

FULL NAME Ruth Ester Turner

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)	DATE OF DEATH <u>Jan. 22, 1916</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Jan 27, 1912</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan 19, 1916</u> , to <u>Jan 22, 1916</u> , that I last saw her alive on <u>Jan 22, 1916</u> , and that death occurred, on the date stated above, at <u>2 a.m.</u> The CAUSE OF DEATH* was as follows:	
AGE <u>3</u> yrs. <u>11</u> mos. <u>26</u> ds. IF LESS than 1 day, ____ hrs. or ____ min.?			<u>Cerebro Spinal Meningitis</u> <u>7:4 A</u> (Duration) ____ yrs. ____ mos. <u>10</u> ds.	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory _____ (Duration) ____ yrs. ____ mos. ____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>			(Signed) <u>F. L. McCormick</u> , M. D. <u>Jan. 26, 1916</u> (Address) <u>Huntsville, Mo.</u>	
PARENTS	NAME OF FATHER <u>B. E. Turner</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Randolph Co. Mo.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.	
	MAIDEN NAME OF MOTHER <u>Rosa Schuermann</u>		Where was disease contracted if not at place of death? _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Randolph Co. Mo.</u>		Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>B. E. Turner</u> (ADDRESS) <u>Huntsville</u>			PLACE OF BURIAL OR REMOVAL <u>Trinity</u> UNDERTAKER <u>Andrew Wilson</u>	
File No. <u>747th</u> <u>Jan 23</u> 1916 <u>44 Bragg</u> REGISTRAR			DATE OF BURIAL <u>Jan 23, 1916</u> ADDRESS <u>Huntsville</u>	

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*, *peritonaeum*, 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.)



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1 PLACE OF DEATH

County

Township

Village

City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
(Month) (Day) (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)
(Address)

15 Filed *Feb 3* 1916 *G. Y. Bragg*
Registrar

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

Registration District No.

Primary Registration District No.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No.

Registered No.

St. Ward)

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

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from
191..... to..... 191.....
that I last saw h..... alive..... 191.....
and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:
*Cerebrospinal meningitis
Tubercular*
(Duration) *6* yrs. mos. ds.

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

(Signed) *J. J. McCormick*
Jan 26 1916 (Address) *Huntsville*

*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

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]

3028

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