

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 DeKalb
Township Washington Registration District No. 261 File No. 5961
or
Village X Primary Registration District No. 4400 Registered No. 63
or
City X (NO. 5361B St. _____ Ward _____)

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

FULL NAME Mrs Ethel Coffey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE - MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>March 17, 1888</u> (Month) (Day) (Year)		
AGE <u>27</u> yrs. <u>10</u> mos. <u>2</u> wks.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeping</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Clinton County Mo.</u>		
PARENTS	NAME OF FATHER <u>Reuben E Kerns</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Mary Boyer</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Clinton County Mo.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harvey Kerns
(ADDRESS) Easton Mo.

Filed Feb 14, 1916 J. E. Saunders
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 13, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 2, 1916, to Feb 12, 1916, that I last saw her alive on Feb 6, 1916, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Influenza
10 ↓
(Duration) 0 yrs. 0 mos. 14 ds.
Contributory Meningitis
(SECONDARY) (Duration) 0 yrs. 0 mos. 3 ds.

(Signed) H. A. Calvert M. D.
Feb 13, 1916 (Address) Easton 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 Easton Mo DATE OF BURIAL Feb 15, 1916
Freeman Kerns

UNDERTAKER

F. G. Lyon

ADDRESS

Stewartville Mo

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.)



1 PLACE OF DEATH

County

De Kalb
Washington

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

Registration District No.

261

File No.

Village

Primary Registration District No.

536013

Registered No.

63

City

NO.

St.

Ward

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

2 FULL NAME

Mrs. Ethel Coffey

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *February 13 1916*
(Month) (Day) (Year)

7 AGE *28* yrs. *10* mos. *28* ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Clinton Co. Mo.*

10 NAME OF FATHER *Reuben Kerns*

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

12 MAIDEN NAME OF MOTHER *Mary Boyer*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Clinton Co. Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *H. Kerns* (Address) *Easton Mo*

15 Filed *Feb 14 1916* *T. E. Sammons* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb. 13 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *February 1916* to *Feb 13 1916* that I last saw her alive on *Feb 12 1916* and that death occurred, on the date stated above, at *6:00 A.M.*

The CAUSE OF DEATH* was as follows:
Influenza

CONTRIBUTORY *Menigitis (Pfeiffer's)*
(Secondary) (Duration) yrs. mos. *14* ds.

(Signed) *H. A. Calvert* M. D.
2-13-1916 (Address) *Easton, 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? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191

20 UNDERTAKER ADDRESS

Supplemental

Revised United States Standard Certificate of Death

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

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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), *29ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Athenia," "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.)