

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

1 PLACE OF DEATH  
County Henry

Township \_\_\_\_\_ or \_\_\_\_\_  
Village \_\_\_\_\_ or \_\_\_\_\_  
City Clinton Mo (No. 213 E Jeff St. 4<sup>th</sup> Ward)

Registration District No. 350 File No. 6224  
Primary Registration District No. 2018 Registered No. 11

2 FULL NAME Margaret Elisabeth Bitts

(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 white SINGLE MARRIED WIDOWED OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH April 8 1832  
(Month) (Day) (Year)

7 AGE 83 yrs 10 mos 7 ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Washington Mo

PARENTS  
10 NAME OF FATHER Dyson Johnson  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) North Carolina  
12 MAIDEN NAME OF MOTHER Margaret Johnson  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Virginia J. Turner  
(Address) Clinton Mo

15 Filed Feb 16 1916 J. M. Shurtland  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 15 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 2-7-1916 to 2-10-1916  
that I last saw him alive on 2-15-1916  
and that death occurred, on the date stated above, at 5:31 p.m.

The CAUSE OF DEATH\* was as follows:  
11<sup>th</sup> Influenza  
12<sup>th</sup> Pneumonia

CONTRIBUTORY (Secondary) Pneumonia  
(Duration) yrs. mos. 7 ds.  
(Signed) A. J. Greenlee M. D.  
(Address) Clinton, Mo

\*State the Disease Causing Death, or, in death 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 Windsor Mo DATE OF BURIAL Feb 17 1916

20 UNDERTAKER E. E. Pope ADDRESS Clinton 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*, *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*, *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.)

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

1 PLACE OF DEATH  
County Henry  
Township or Village or City Clinton

Registration District No. 350 File No.  
Primary Registration District No. 3018 Registered No. 11  
(NO. St. Ward)

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

2 FULL NAME Margaret Elizabeth Butts.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

18 DATE OF DEATH Feb. 15 1916  
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191

7 AGE yrs. mos. da. If LESS than 1 day... hrs. or... min.?

that I last saw him alive on 191 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH\* was as follows: Infection Supplied.

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

Influenza

9 BIRTHPLACE (City or town, State or foreign country)

(Duration) yrs. mos. da. CONTRIBUTORY Broncho Pneumonia (Secondary)

10 NAME OF FATHER

(Duration) yrs. mos. da. (Signed) M. D.

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

Mar 30, 1916 (Address) Clinton Mo

12 MAIDEN NAME OF MOTHER

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

At place of death yrs. mos. da. In the State yrs. mos. da. Where was disease contracted if not at place of death? Former or usual residence

15 Filed March 20 1916 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191... 20 UNDERTAKER ADDRESS

SUPPLEMENTARY

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MISSOURI STATE BOARD OF HEALTH

# Revised United States Standard Certificate of Death

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

4229

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