

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

1 PLACE OF DEATH

County Miller
Township Glauze
or
Village Burnley
or
City (NO. St.: Ward)

Registration District No. 1164 File No. 10 7265
Primary Registration District No. 57619 Registered No. 10

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

2 FULL NAME Mary Musick

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>
AGE OF BIRTH <u>Feb</u> <u>5</u> <u>1916</u> (Month) (Day) (Year)		
OCCUPATION Trade, profession, or particular kind of work <u>nil</u>		If LESS than 1 day, hrs. or min.? yrs. mos. <u>2</u> ds.
General nature of industry, business, or establishment in which employed (or employer) <u>nil</u>		
BIRTHPLACE City or town, or foreign country <u>Burnley Mo.,</u>		
10 NAME OF FATHER <u>W. E. Musick</u>		
11 BIRTHPLACE OF FATHER City or town, State or foreign country <u>Washington Co., Ark.</u>		
12 MAIDEN NAME OF MOTHER <u>Stella A. Jolly</u>		
13 BIRTHPLACE OF MOTHER City or town, State or foreign country <u>Miller Co Mo.,</u>		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Feb 7, 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 5, 1916, to Feb 7, 1916, that I last saw her alive on Feb 5, 1916, and that death occurred, on the date stated above, at 8:00 pm.

The CAUSE OF DEATH* was as follows:
Premature Birth.

(Duration) yrs. mos. ds.

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

(Signed) P. Thompson M. D.
Feb 7, 1916 (Address) Burnley 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. 2 ds. In the State yrs. mos. 2 ds.

Where was disease contracted if not at place of death? Home

Former or usual residence Burnley Mo.,

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. G. Wall
(Address) Burnley Mo.,

19 PLACE OF BURIAL OR REMOVAL <u>Hawkins Cemetery</u>	DATE OF BURIAL <u>Feb 7</u> , 191 <u>6</u>
20 UNDERTAKER <u>Thompson</u>	ADDRESS <u>Burnley Mo.,</u>

Filed Feb 9, 1916
Registrar

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, 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.)

CERTIFICATE OF DEATH.

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

1 PLACE OF DEATH

County Miller
Township Glauze
or
Village
or
City

Registration District No. 1161 File No.

Primary Registration District No. 5761A Registered No. 10

(NO. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Musiek

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH:

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

16 DATE OF DEATH Feb 7 1916
(Month) (Day) (Year)

6 DATE OF BIRTH Feb 1 1891
(Month) (Day) (Year)

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

7 AGE 25 yrs. 1 mos. 1 ds.
If LESS than
1 day... hrs.
or... min. P

The CAUSE OF DEATH* was as follows:

8 OCCUPATION
(a) Trade, profession, or
regular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)
(c) PLACE
where born, or
of foreign country)

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

9 BIRTH (City, State)
10 NAME OF FATHER

(Signed) M. D.
(Address) 191...

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)

*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

14 (Informant) (Address)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191...

20 Filed Feb 24 1916 J. L. Conner M.D. Registrar

20 UNDERTAKER ADDRESS

Original file, date, 19...

All information called for must be written on this Supplementary Certificate.

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.

SUPPLEMENTARY

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, 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.)