

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

PLACE OF DEATH

County Sullivan
Township Jackson
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 856
Primary Registration District No. 6124

File No. 8861
Registered No. _____

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

FULL NAME Constance Virginia Crumacker

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Widowed
OR WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH July 11, 1829
(Month) (Day) (Year)

AGE 86 6 13 If LESS than
1 day, ___ hrs. or ___ mln.?
yrs. mos. ds.

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

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

PARENTS
NAME OF FATHER William Oglesby
BIRTHPLACE OF FATHER Don't know
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER Don't know
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Crumacker
(ADDRESS) Bellevue Mo

Filed _____, 191____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 4, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 2, 1916, to Feb 4, 1916 that I last saw her alive on Feb. 3, 1916, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:
Senile Pneumonia

11 1/2 (Duration) yrs. 10 mos. 4 ds.

Contributory Lathippe
(SECONDARY) (Duration) yrs. 8 mos. 10 ds.

(Signed) G. M. J. Williams M. D.
Feb. 4, 1916 (Address) Palmer 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 Bellevue Mo DATE OF BURIAL Feb 6, 1916
Crumacker New Putnam

UNDERTAKER C. J. Schaefer ADDRESS Bellevue Mo

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.

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.)

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

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

1 PLACE OF DEATH
 County Sullivan
 Township or Village or City Jackson

Registration District No. 856 File No. _____
 Primary Registration District No. 6124 Registered No. _____
 (NO. _____) (St. _____) (Ward _____)

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

2 FULL NAME

Constance Virginia Crumpacker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W.</u>
6 DATE OF BIRTH _____. _____. 191____ (Month) (Day) (Year)		
7 AGE ____ yrs. ____ mos. ____ da.		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)	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
 _____ 191____
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 191____ to _____ 191____, that I last saw h..... alive on _____ 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: supplied

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

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

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

*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

SUPPLEMENTARY

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

15 Filed Feb 4 1916 M. J. Williams
 Registrar

Revised United States Standard Certificate of Death

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

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