

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

PLACE OF DEATH
County Lewis
Township
or
Village Lewistown
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 481 File No. 10966
Primary Registration District No. 4290 Registered No. 8

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

FULL NAME Mattie T. Wright

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)
DATE OF BIRTH March 24, 1836
(Month) (Day) (Year)
AGE 79 yrs. 11 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Harrodsburg, Kentucky
PARENTS
NAME OF FATHER W. Thomas
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Schenker
(ADDRESS) Lewistown Mo
Filed March 21, 1916 J. C. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 21, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 11, 1916, to March 21, 1916, that I last saw her alive on March 20, 1916, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
1854 Paralysis
1943
87A

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory fractured femur
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) R. B. Schenker M. D.
March 21, 1916 (Address) Lewistown 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 La. Grange Mo. DATE OF BURIAL March 22, 1916
UNDERTAKER J. A. Coder ADDRESS Lewistown 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*, *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*, *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), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthensia," "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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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *Lewis*
Township or Village or City *Leungton*

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

Registration District No. *H 81* File No. *1*
Primary Registration District No. *H 290* Registered No. *8*
St. Ward

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

2 FULL NAME

Mattie T Wright

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *F* 4 COLOR OR RACE *W.* 5 SINGLE MARRIED WIDOWED OR DIVORCED *W.*
(Write the word)
6 DATE OF BIRTH
7 AGE
8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

16 DATE OF DEATH *3-21-1916*
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from the time he/she was first seen alive on 191..... and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Paralysis - paretic type of right side due to cerebral hemorrhage.
(Duration) yrs. mos. ds.

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)

CONTRIBUTORY (Secondary) *fractured femur from a fall*
(Duration) yrs. mos. ds.
(Signed) *R. B. Schmitt* M.
3-2 191..... (Address) *Levinstown, Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(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 *5* yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence *La Grange, Mo.*

15 Filed *May 2* 1916 *J. E. Brown* Registrar

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

SUPPLEMENTARY

Original file, date....., 1916

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

Revised United States Standard Certificate of Death

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