

## 1 PLACE OF DEATH

County BuchananTownship.....  
orVillage.....  
orCity St. JosephRegistration District No. 85File No. 30505-1Primary Registration District No. 1001Registered No. 996(NO. 806 N. 6th St.:..... Ward)

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

2 FULL NAME Eather E. O'Connell

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married16 DATE OF DEATH Sept 19th 1916  
(Month) (Day) (Year)6 DATE OF BIRTH Apr. 18th 1887  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from June 7 1916, to Sept 19 1916, that I last saw her alive on Sept 19 1916, and that death occurred, on the date stated above, at 7<sup>20</sup> P. m.7 AGE 29 yrs. 5 mos. X ds. If LESS than 1 day,.....hrs. or.....min.?

The CAUSE OF DEATH\* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work House wife (b) General nature of industry business, or establishment in which employed (or employer) at homeDiabetes Mellitus  
59  
20  
50  
..... (Duration) ..... yrs. 5 mos. .... ds.9 BIRTHPLACE (City or town, State or foreign country) Missouri

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

10 NAME OF FATHER H.T. Miller11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany12 MAIDEN NAME OF MOTHER Hattie Sedwick13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri(Signed) Felix St. M. D. Sept 20 1916 (Address) 716 1/2 Felix St.

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. O'Connell  
(Address) 711 N. 10<sup>th</sup> St

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.....

15 Filed Sept 20 1916 M. P. Beard Registrar19 PLACE OF BURIAL OR REMOVAL Mt. Mora Cem. DATE OF BURIAL Sept 21 191620 UNDERTAKER Fleeman-Beaton ADDRESS 1208 Francis

# 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*, *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 "Asthemia," "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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' certificates very important. DATE OF DEATH in years, so that it may be properly classified. Exact statement of OCCUPATION.

1 PLACE OF DEATH

County Buchanan

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

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

Township or Village or City St. Joseph

Registration District No. 85 Primary Registration District No. 1001

File No. Registered No. 996

2 FULL NAME

Esther E. O'Connell

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE yrs. mos. ds. 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)

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)

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

15 Filed Sept 20 1916 W. A. Keely Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) Sept. (Day) 19 (Year) 1916

17 I HEREBY CERTIFY, that I attended deceased from (Month) 191 to (Month) 191 that I last saw (Month) 191 and that death occurred on the date stated above, at (Month) 191

The CAUSE OF DEATH\* was as follows: Satisfactory Information Supplied.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Address) 191

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

19 PLACED IN CASK OR REMOVAL M. Mora Cem. DATE OF BURIAL Sept. 21 1916

20 UNDERTAKER Hoarman - Astoria ADDRESS 1208 Francis

SUPPLEMENTARY INFORMATION Supplied.

Original file, date SEP 1916, 19

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

# Revised United States Standard Certificate of Death

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