

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Baldwell

Township \_\_\_\_\_

or

Village \_\_\_\_\_

City Hamilton (NO. \_\_\_\_\_)

Registration District No. 96

File No. 30570

Primary Registration District No. 4058

Registered No. 42

St. 2 Ward \_\_\_\_\_

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

FULL NAME Lucretia E. Toon

PERSONAL AND STATISTICAL PARTICULARS

SEX 1 COLOR OR RACE \_\_\_\_\_ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH July 13, 1848  
(Month) (Day) (Year)

AGE 68 yrs. 2 mos. 7 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

NAME OF FATHER Wesley Stewart

BIRTHPLACE OF FATHER (City or town, State or foreign country) N. Ken

MAIDEN NAME OF MOTHER Lucretia Stewart

BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. Ken

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) all Toon

(ADDRESS) Hamilton

Filed Sept 21 1916 J. M. J. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH September 20, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 1<sup>st</sup>, 1916, to September 20, 1916, that I last saw her alive on September 20, 1916, and that death occurred, on the date stated above, at 2<sup>30</sup> m.

The CAUSE OF DEATH\* was as follows:  
Cancer of Liver and Small Intestines  
1 1/2 (Duration) yrs. 10 mos. ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.

(Signed) H. E. Pappas M. D. 7/21 1916 (Address) Hamilton, 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 Highland Cemetery DATE OF BURIAL Sept 22 1916

UNDERTAKER Ornicks ADDRESS Hamilton

N. B. 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, 8 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 organ; "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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

*Caldwell*

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

Township

Registration District No.

*96*

File No.

Village

Primary Registration District No.

*4058*

Registered No.

*42*

City

*Hamilton*

(NO.

St.

Ward)

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

2 FULL NAME

*Lucretia E. Toon*

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)

*Widow*

16 DATE OF DEATH

*9/20/1916*

6 DATE OF BIRTH

(Month) (Day) (Year)

7 AGE

If LESS than 1 day... hrs. or... min.?

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

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH\* was as follows:

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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Albert Toon*

(Address)

*Hamilton, Mo.*

15

Filed

1916

*Sept 21 Truly Mouri*

Registrar

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(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

Original file, date

*Sept 21 1916*

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

SUPPLEMENTARY Satisfactory Information Supplied

Every item should be stated EXACTLY. PHYSICIAN should state occupation in very important.

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