

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

1 PLACE OF DEATH

County *Cape Girardeau*

Township *Cape Girardeau*

Village _____

City *Cape Gir. Mo.* (NO. *St. Francis Hospital 3* Ward)

Registration District No. *135*

File No. *30611*

Primary Registration District No. *3009*

Registered No. *1438*

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

2 FULL NAME *Etta Mahrey*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Married*
(Write the word)

10 DATE OF DEATH *Sept 12* 191*6*
(Month) (Day) (Year)

6 DATE OF BIRTH *Oct 3* 18*73*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Sept 11* 191*6* to *Sept 12* 191*6*, that I last saw her alive on *Sept 12* 191*6*, and that death occurred, on the date stated above, at *6 a.m.*

7 AGE *40* yrs. *11* mos. *9* ds. If LESS than 1 day... hrs. or... min.?

The CAUSE OF DEATH* was as follows:
Rupture of Uterus
2 hrs.
(Duration) yrs. mos. *2* hrs. ds.

8 OCCUPATION (a) Trade, profession, or particular kind of work *House Keeper*
(b) General nature of industry business, or establishment in which employed (or employer)

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

9 BIRTHPLACE (City or town, State or foreign country) *Cape County Mo.*

PARENTS 10 NAME OF FATHER *Burton Cawon*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *North Carolina*
12 MAIDEN NAME OF MOTHER *Lourenda Wingate*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Cape Gir. Mo.*

(Signed) *George H. St. Alban* M. D. *9/12* 191*6* (Address) *Cape Girardeau 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. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *W. C. Cawon*
(Address) *Cape Gir. Mo.*

19 PLACE OF BURIAL OR REMOVAL *Fairmount Cemetery* DATE OF BURIAL *Sept 13* 191*6*

15 Filed *Sept 13* 191*6* *R. H. Finney* Registrar

20 UNDERTAKER *Lorberg-Turney and Co* ADDRESS *Cape Gir. Mo.*

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, 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.)

1 PLACE OF DEATH

County

Cape Girardeau

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

Township

Registration District No.

125

File No.

Village

Primary Registration District No.

3009

Registered No.

1428

City

Cape Girardeau

St. Ward

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

2 FULL NAME

Etta Mabrey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

F *W.* *M.*

16 DATE OF DEATH

Sept. 12 1916

6 DATE OF BIRTH

(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from

Satisfactory Information Supplied

7 AGE

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

and that death occurred, on the date stated above, at

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:

*Rupture of Uterus
Puerperal*
136 hrs.

9 BIRTHPLACE

(City or town,
State or foreign country)

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

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)

(Signed) *George Stophel* M.D.

9/12 1916 (Address) *Cape Girardeau*

*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)

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Where was disease contracted if not at place of death?

Former or usual residence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

15

Filed

Oct 31, 1916 *R. W. Fernald*

Registrar

20 UNDERTAKER

ADDRESS

Original file, date

SEP 1916

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

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. For Exact statement of OCCASION 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 "Asthénia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhago," "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 septichaemia," "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.)