

Dr Collins

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

PLACE OF DEATH

County Pettis

Township _____

or _____

Village _____

or Sedalia

City _____

Registration District No. 668

File No. 35212

Primary Registration District No. 2032

Registered No. 279

(NO. St Marys Hospital St.: _____ Ward) _____

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

FULL NAME Mary Lou Ellen Devine

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb, 1916
(Month) (Day) (Year)

AGE 21 yrs. 2 mos. 1 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

NAME OF FATHER Pete Devine

BIRTHPLACE OF FATHER (City or town, State or foreign country) Cooper Co Mo

MAIDEN NAME OF MOTHER Lou Ellen Connor

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lamotte Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. C. Connor

(ADDRESS) Sedalia Mo

Filed Oct 5, 1916 H. W. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct, 1916
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Oct 24, 1916, to Oct 24, 1916, that I last saw her alive on Oct 24, 1916,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:
Meningitis (acute)
17037
9987

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

Contributory Colon Bacilli

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

(Signed) M. J. Pelgion M. D. Oct 5, 1916 (Address) Sedalia 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 Sedalia Mo DATE OF BURIAL Oct 5, 1916

UNDERTAKER McLaughlin Bros Sessing ADDRESS _____

PLACE OF DEATH

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

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)	AGE _____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

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

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

NAME OF FATHER _____

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191_____

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191_____ (Month) _____ (Day) _____ (Year)

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:

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

Contributory _____

(SECONDARY)

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

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

*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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191_____

UNDERTAKER _____

ADDRESS _____

PLACE OF DEATH
Pettis

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

County
Township
or
Village
of
City (NO. Ward)
Registration District No. *668* File No.
Primary Registration District No. *3032* Registered No. *273*

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

²FULL NAME *Mary Lou Ellen Devine*

PERSONAL AND STATISTICAL PARTICULARS

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

⁶DATE OF BIRTH
(Month) (Day) 1 (Year)

⁷AGE
IF LESS than 1 day hrs. or min.?
yrs. mos. ds.

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

⁹BIRTHPLACE
(City or town, State or foreign country)

PARENTS
¹⁰NAME OF FATHER
¹¹BIRTHPLACE OF FATHER (City or town, State or foreign country)
¹²MAIDEN NAME OF MOTHER
¹³BIRTHPLACE OF MOTHER (City or town, State or foreign country)

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

¹⁵Filed *Oct 6 1916* *M. B. [Signature]*
Registrar

MEDICAL CERTIFICATE OF DEATH

¹⁶DATE OF DEATH *Oct. 4 1916*
(Month) (Day) (Year)

¹⁷I HEREBY CERTIFY, that I attended deceased from *Oct 4 1916* to 191.....
that I last saw him alive on 191.....
and that death occurred, on the date stated above, at m.

CAUSE OF DEATH* as follows:
(Acute) Meningitis
not epidemic
bl
(Duration) yrs. mos. *3* ds.

CONTRIBUTORY *Colon Bacilli*
(Secondary)
(Duration) yrs. mos. *3* ds.
(Signed) *M. J. [Signature]* M. D.
Oct 5 1916 (Address) *Sedalia Mo.*

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
¹⁸LENGTH 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

¹⁹PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
²⁰UNDERTAKER ADDRESS

SUPPLEMENTARY

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, peritonacum, 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 "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.)

35212