

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

36501

1 PLACE OF DEATH

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

Registration District No. 820

File No. _____

Primary Registration District No. 6069

Registered No. 160

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

2 FULL NAME

Florine Halter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Aug 2, 1915
(Month) (Day) (Year)

7 AGE 1 yrs 1 mos 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) _____

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

10 NAME OF FATHER Phelley Halter
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Mary Wilder
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Phelley Halter
(Address) Ch. office Mo

15 Filed Oct 10, 1916 J. H. Henry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 20, 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw her alive on 9/20, 1916, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:
Diagnosis not made. (was seen only one hour before death) St. Colitis (?)
119B (Duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (Secondary) 104 (Duration) _____ yrs. _____ mos. _____ ds.
8 (Signed) J. A. Cline M. D.
9/21, 1916 (Address) Oran 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 _____

19 PLACE OF BURIAL OR REMOVAL Chaffee Cemetery DATE OF BURIAL 9/21, 1916

20 UNDERTAKER Hessner & Co ADDRESS Oran 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

will be sufficient, e. g., *Farmer* or *in*, *Compositor*, *Architect*, *Locomotive engineer*, *Stationary fireman*, etc. But specially in industrial employments, know (a) the kind of work and also the business or industry, and there-
linal line is provided for the latter
ould be used only when needed.

Spinner, (b) *Cotton mill*; (a) *Sales-*
(a) *Foreman*, (b) *Automobile factory*.
ked on may form part of the second
er return "Laborer," "Foreman,"
ealer," etc., without more precise
Day laborer, *Farm laborer*, *Laborer*—

Women at home, who are engaged
the household only (not paid *House-*
ve 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 occu-
pations 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*; *Broncho-*
pneumonia ("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 in-
tercurrent) affection need not be stated unless im-
portant. 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 mis-
carriage, as "PUERPERAL septicaemia," "PUERPERAL
peritonitis," etc. State cause for which surgical oper-
ation was undertaken. For VIOLENT DEATHS state
MEANS OF INJURY and qualify as ACCIDENTAL, SUI-
CIDAL, OR HOMICIDAL, or as *probably* such, if impos-
sible 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 "Con-
tributory." (Recommendations on statement of
cause of death approved by Committee on Nomen-
clature of the American Medical Association.)