

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

38208

1 PLACE OF DEATH

County Miller

Township \_\_\_\_\_

Village \_\_\_\_\_

City \_\_\_\_\_

Registration District No. 561

File No. \_\_\_\_\_

Primary Registration District No. 4270

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

2 FULL NAME

Harriett Dooley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE widowed  
MARRIED  
WIDOWED  
OF DIVORCED  
(Write the word)

6 DATE OF BIRTH Doyle Knoxville  
(Month) (Day) (Year)

about 93 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION Housewife  
Trade, profession, or other kind of work  
General nature of industry, business, or establishment in which employed (or employer)

PLACE OF BIRTH Some place in Tenn  
(City or town, State or foreign country)

NAME OF FATHER Doyle Knowlton

11 BIRTHPLACE OF FATHER Doyle Knoxville  
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER Harriett Dooley

13 BIRTHPLACE OF MOTHER Doyle Knoxville  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Francis Robertson  
(Address) Edson Mrs

15 Filed 11/8 1916 J. J. Campbell  
Registrar

7 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 7 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 1 1916 to Nov 7 1916

that I last saw her alive on Nov 1 1916

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:  
Endo Carditis  
131  
9713

(Duration) yrs. mos. ds. 6

CONTRIBUTORY Chronic Nephritis  
(Secondary)

(Duration) yrs. mos. ds. 2

(Signed) W. E. Allen M. D.  
Nov 8 1916 (Address) Edson Mrs

\*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 Not Reported DATE OF BURIAL \_\_\_\_\_ 1916

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# 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 "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  
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CERTIFICATE OF DEATH

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

1 PLACE OF DEATH  
*Miller*  
County.....  
Township.....  
or  
Village.....  
of  
City *Eldon* (NO. .... St. .... Ward)

Registration District No. *561* File No. ....  
Primary Registration District No. *4330* Registered No. ....

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

2 FULL NAME *Hammet Spoley*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *11-7-1916*  
(Month) (Day) (Year)

6 DAY OF BIRTH ..... (Month) ..... (Day) 1 (Year) .....

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

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

The CAUSE OF DEATH\* was as follows:

8 OCCUPATION  
(a) Trade, profession, or kind of work  
(b) General business (or employer)

*This was an old man who was unable to walk without crutches.*  
(Duration) ..... yrs. .... mos. .... ds.

9 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)

CONTRIBUTORY (Secondary) *Register of Dr. J. M. Spoley*  
(Duration) ..... yrs. .... mos. .... ds.  
(Signed) *J. M. Spoley* M. D.  
191... (Address) .....

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

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

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

Where was disease contracted if not at place of death?  
Former or usual residence .....

21 FILED *X 11/8 1916* Registrar

SUPPLEMENTARY

Original file, date, NOV 19 1916

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

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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 "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.)

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