

PLACE OF DEATH.

STATE OF ~~MISSOURI~~ MISSOURI.County Platte

STATE BOARD OF HEALTH—DIVISION OF VITAL STATISTICS.

38461

Township Lee

STANDARD CERTIFICATE OF DEATH.

City East Leonard Mo.Registered 694ward. No. 694Full Name Adelia Butler

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

PERSONAL AND STATISTICAL PARTICULARS.

3 Sex F 4 Color or Race W 5 Single, Married, Widowed, or Divorced. M
(Write the word.)

6 Date of Birth February 5 1855
(Month) (Day) (Year)

7 Age 64 yrs. mos. ds. or min. If LESS than 1 day, hrs.

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

9 Birthplace Wis
(State or country).

10 Name of Father Geo. Moorhan

11 Birthplace of Father Ireland
(State or country).

12 Maiden name of Mother

13 Birthplace of Mother Ireland
(State or country).

14 The above is true to the best of my knowledge.

(Informant) T. C. Butler(Address) East Leonard Mo.

15 Filed 11-7 1916 6 East Leonard Mo. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16 Date of Death Nov 27 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 1916 to Nov 4 1916

that I last saw her alive on Nov 3 1916

and that death occurred on the date stated above, at 7:00 M.

THE CAUSE OF DEATH was as follows:

Erysipelas
V 150 9:30 (Duration) 18 yrs. 6 mos. 6 ds.

Contributory (Secondary) ---
(Duration) yrs. mos. ds.

(Signed) [Signature] M. D.
1916 (Address) East Leonard 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 Smith Cemetery Date of Burial Nov 6 1916

20 Undertaker J. C. Davis Undertaking Co. Address City

Approved by United States 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, 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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichæmia," "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 carbonic 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

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

CERTIFICATE OF DEATH

PLACE OF DEATH
Platte
Des
County
Township
or
Village
or
City

Registration District No. *694* File No.
Primary Registration District No. *5921* Registered No.
City (NO. St. Ward)

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

2 FULL NAME *Adelia Butner*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) (Year) *1*

7 AGE yrs. mos. *Satisfactory Information Supplied.*

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

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) *Satisfactory Information Supplied.* (Address)

15 Filed *X* 191 *1* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov. 4 1916*

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) *1916* to (Month) (Day) (Year) *1916*

that I last saw him alive on (Month) (Day) (Year) *1916* and that death occurred, on the date stated above, at (Month) (Day) (Year) (Time) *11/4 6*

The CAUSE OF DEATH* was as follows: *Encephalitis febrile myocarditis*

CONTRIBUTORY (Secondary) *Facial erysipelas* (Duration) (yrs.) (mos.) (ds.) *6*

(Signed) *W. H. [Signature]* 191 *6* (Address) *Leavenworth Ave*

*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

20 UNDERTAKER ADDRESS

SUPPLEMENTARY CERTIFICATE

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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APPROVED AND SIGNED (to be filled in by the physician or other qualified person):
 (Signature)
 (Print name of physician or other qualified person)
 (Address of physician or other qualified person)

U. S. DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF STATISTICS

UNRECORDED
 DATE OF ENTRY
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