

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

1 PLACE OF DEATH

County Shelby
Township Taylor
or
Village
or
City

Registration District No. 1833 File No. 39668
Primary Registration District No. 6096 Registered No. 24
St. Ward

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

2 FULL NAME Amanda Ella Hensley

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Feb 18 1869
(Month) (Day) (Year)

7 AGE 47 yrs 8 mos 12 ds. IF LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER Thomas G Atkins

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

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ida Nute
(Address) Bevier mo

15 Filed Nov 1 1916 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 25 1916 to Oct 30 1916, that I last saw her alive on Oct 30 1916 and that death occurred, on the date stated above, at 7 A m. The CAUSE OF DEATH* was as follows:

107A
Bronchial Pneumonia
91
Duration) yrs mos. 7 ds.

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

(Signed) Dr P Case M. D. Oct 30 1916 (Address) Cherry Box 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 Cherry Box mo DATE OF BURIAL Oct 31 1916

20 UNDERTAKER John Hudson ADDRESS Novelty 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*, *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.)

1 PLACE OF DEATH

County

Township

Village

City

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

Registration District No.

Primary Registration District No.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No.

Registered No.

(NO.

St.

Ward)

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OF FACE *W.* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *W.*6 DATE OF BIRTH *Feb 18 1869*
(Month) (Day) (Year)7 AGE *47* yrs. *8* mos. *12* ds. If LESS than 1 day... hrs. or... min.?8 OCCUPATION (a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*9 BIRTHPLACE (City or town, State or foreign country) *Randolph Mo*10 NAME OF FATHER *Thomas Perkins*11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Mo*12 MAIDEN NAME OF MOTHER *not known*13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *not known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

(Address)

15

Filed *Jan 8* 191*7*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct. 30 1916*
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Oct 27* 191*6* to *Oct 30* 191*6*that I last saw h. *alive on Oct 30* 191*6*and that death occurred, on the date stated above, at *7* m.

The CAUSE OF DEATH? was as follows:

*Bronchial Pneumonia**91*(Duration) *7* mos. *7* ds.

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. *7* mos. *7* ds.(Signed) *E R Rose* M. D.*Oct 30* 191*6* (Address) *Cherry Box 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 *7* yrs. *7* mos. *7* ds. In the State *7* yrs. *7* mos. *7* ds.

Where was disease contracted if not at place of death?

Former or usual residence *7* yrs. *7* mos. *7* ds.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry Box Mo *Oct 31* 191*6*

20 UNDERTAKER

ADDRESS

John Hudson *Novelty Mo*

Original file, date.

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

Revised United States Standard Certificate of Death

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

89963

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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.)