

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

PLACE OF DEATH
County Caldwell
Township Grout or Village _____ or City Polo (NO. _____ St. _____ Ward _____)
Registration District No. 99 File No. 40172
Primary Registration District No. 4061 Registered No. 80

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

FULL NAME Elizabeth Hyder

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widow</u> (Write the word)
DATE OF BIRTH <u>Oct 22</u> , 1 <u>899</u> (Month) (Day) (Year)		
AGE <u>77</u> yrs. <u>1</u> mos. <u>22</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>Josiah Jennings</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Not known</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>✓</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 13, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 12, 1916, to Dec 13, 1916, that I last saw her alive on Dec 13, 1916, and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
9.5 l.
178 c.
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W L Davis M. D.
Dec 15, 1916 (Address) Polo 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Belle Sumrell
(ADDRESS) Polo Mo

Filed Dec 15, 1916, B L Mount REGISTRAR

PLACE OF BURIAL OR REMOVAL Gothan Lane Ray Co DATE OF BURIAL Dec 15, 1916

UNDERTAKER Alsbaugh & Cowley ADDRESS Polo Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 "Asthemia," "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 CaldwellREGISTRARS SHALL NOT RECEIVE
A FEE FOR CERTIFICATES UNTIL THEY
ARE COMPLETED AS PRESCRIBED BY
LAW

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Township

Registration District No. 99

File No.

Village

Primary Registration District No. 4061Registered No. 20City Pola (NO. St. Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Elizabeth Snyder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
4 COLOR OR RACE
5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6 DATE OF BIRTH
(Month) (Day) 1 (Year)7 AGE
If LESS than
1 day.....hrs.
or.....min.?
.....yrs.....mos.....ds.8 OCCUPATION
(a) Trade, profession, or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)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)

(Address)

15
Filed..... 191.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Dec. 13 1916
(Month) (Day) (Year)17 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:

Acute Indigestion
with Cardiac Dilatation
(Duration) 19 yrs..... mos..... ds.CONTRIBUTORY:
(Secondary)
(Duration) yrs..... mos..... ds.
(Signed) W. Z. Davis M. D.
Feb 19 1917 (Address) Pola 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 DATE OF BURIAL
..... 191.....

20 UNDERTAKER ADDRESS

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