

PLACE OF DEATH

Shelby
Black CreekMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 831

File No.

Primary Registration District No. 6092

Registered No. 43581

(NO. St. Ward)

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

FULL NAME Sarah Ellen Melick Hart

PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Married

BIRTH June 8, 1849 (Month) (Day) (Year)

67 yrs. 5 mos. 24 ds. If LESS than 1 day, hrs. or min.?

Profession, or kind of work Housewife
Nature of Industry, establishment in which employed (or employer) XCountry Strattonville, N.J.
Name of Father James MelickPLACE OF BIRTH New Jersey
Name of Mother Rebecca Melick

PLACE OF BIRTH New Jersey

I AM TRUE TO THE BEST OF MY KNOWLEDGE
Name of Registrar Wm. W. DeckerAddress Strattonville, Mo.
5, 1916
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 2, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1916, to Dec 2, 1916, that I last saw her alive on Dec 2, 1916, and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH[†] was as follows:Impaction of Bowel
1922
1180
(Duration) yrs. mos. 3 ds.

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

(Signed) Starbaker M. D. (Address) Shelbyville, Mo. Dec 5, 1916

*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

PLACE OF BURIAL OR REMOVAL D.O.O. of Gen. Shelbyville, Mo. DATE OF BURIAL Dec. 6, 1916

UNDERTAKER J. W. Thompson Address Shelbyville, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

County.....
 or
 Township.....
 or
 Village.....
 or
 City.....

Registration District No.....
 Primary Registration District No.....

File No.....
 Registered No.....

(NO)....., St. (Ward).....
 of
 hospital
 gave
 of air

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX.....
 COLOR OR RACE.....
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH....., I....., 19..... (Year)
 (Month)..... (Day).....

AGE..... yrs., .. mos., .. ds.
 if less than
 1 day, .. hrs.,
 or .. min.?

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

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

NAME OF FATHER.....

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

MAIDEN NAME OF MOTHER.....

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country).....

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

(ADDRESS).....

Filed....., 19....., REGISTRAR

DATE OF DEATH..... (Month).....

I HEREBY CERTIFY, that I attended....., 19....., to.....
 that I last saw h..... alive on.....
 and that death occurred, on the date stated above

The CAUSE OF DEATH* was as follows:

Contributory..... (Duration)..... yrs.
 (SECONDARY)
 (Signed)..... (Duration)..... yrs.
 (Address).....

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or ho

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS RECENT RESIDENTS)
 At place of death..... yrs., .. mos., .. ds. State..... yrs.
 Where was disease contracted if not at place of death?.....
 Former or usual residence.....

PLACE OF BURIAL OR REMOVAL..... DATE.....

UNDERTAKER.....

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.

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

1 PLACE OF DEATH

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

County Shelby Registration District No. 831 File No. _____
Township Shenandoah or Village _____ or City _____ Primary Registration District No. 6195 Registered No. 35

2 FULL NAME

Sarah Ellen M Hart

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE W 5 SINGLE M MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE 7 If LESS than 1 day _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ 191____ (Month) _____ (Day) _____ (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.

THE CAUSE OF DEATH was as follows:
Impaction of Bowel
Exhaustion following
mounting from recent
Cerebral Stasis
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Impacted Bowel (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.

Signed W.C. 5 1916 (Address) Shelbyville M. D.

*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 _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

Filed Dec 5 1916 W.C. 5 Registrar

Original file, date DEC 1916

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]

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*; *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 inter-current) 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 septichaemia," "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.)