

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

1 PLACE OF DEATH

Stoddard

Ship Pike  
City Bell City

Registration District No. 835

File No. 43584

Primary Registration District No. H. 506

Registered No. 20

(NO. .... St. .... Ward)

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

FULL NAME Emma Mathena

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE

5 SINGLE MARRIED married  
WIDOWED  
OR DIVORCED  
(Write the word)

16 DATE OF DEATH

Oct 31, 1916  
(Month) (Day) (Year)

AGE OF BIRTH

May 5, 1865  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

Oct 30, 1916, to Oct 31, 1916,

that I last saw her alive on Oct 31, 1916,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

congestion of stomach  
and bowels

OCCUPATION

(Trade, profession, or particular kind of work) Housewife

(General nature of industry, business, or establishment in which employed (or employer)) House Keeping

PLACE OF BIRTH

(City or town, State or foreign country) Ark

(Duration) yrs. mos. 2 ds.

10 NAME OF FATHER

John Moore

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country) Ark

(Signed) O. R. Reynolds M. D.

12 MAIDEN NAME OF MOTHER

Don't know

Jan 16, 1916 (Address) Advance Mo

13 BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Don't know

\*State the Disease Causing Death, or, in death 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

BEFORE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signant) Mc Mathena

(Address) Advance Mo

19 PLACE OF BURIAL OR REMOVAL

moore cemetery

DATE OF BURIAL

Nov 1, 1916

20 UNDERTAKER

None

ADDRESS

[Signature]

Oct 10, 1916 O. R. Reynolds  
Registrar

# 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, meningis, 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.)

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.

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1 PLACE OF DEATH

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

CERTIFICATE OF DEATH

County St. Louis Registration District No. 35 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 506 Registered No. 30  
 City Butte City (NO. no 9) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 FULL NAME Lucina Mathena (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M  
 DATE OF BIRTH May 10 1865 (Month) (Day) (Year)  
 AGE 57 yrs. 5 mos. 9 ds. If LESS than 1 day.....hrs. or.....min.?  
 OCCUPATION Housewife  
 Trade, profession, or particular kind of work  
 General nature of industry, profession, or establishment in which employed (or employer) Housekeeping  
 BIRTHPLACE Ark  
 City or town, State or foreign country  
 PARENTS  
 10 NAME OF FATHER John Mathena  
 11 BIRTHPLACE OF FATHER Ark  
 (City or town, State or foreign country)  
 12 MAIDEN NAME OF MOTHER Don't know  
 13 BIRTHPLACE OF MOTHER Don't know  
 (City or town, State or foreign country)

16 DATE OF DEATH Oct 31 1916 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, that I attended deceased from Oct 20 1916 to Oct 31 1916, that I last saw her alive on Oct 31 1916, and that death occurred, on the date stated above, at 11 a.m.  
 The CAUSE OF DEATH\* was as follows:  
Chronic inflammation of stomach  
and intestines  
Compensatory chill  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Signed B. R. Reynolds M. D. Jan 6 1916 (Address) Advance 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Mrs. Mathena  
 (Address) Advance Mo  
 15 Dec 10 1916 B. R. Reynolds  
 Registrar

19 PLACE OF BURIAL OR REMOVAL Moore Cemetery DATE OF BURIAL Nov 1 1916  
 20 UNDERTAKER none ADDRESS \_\_\_\_\_

Final file, date DEC 1916

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

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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.)