

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

604

PLACE OF DEATH  
County Clark  
Township Wyaconda  
or  
Village  
or  
City Wyaconda (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 194 File No. \_\_\_\_\_  
Primary Registration District No. 4117 Registered No. 2

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

FULL NAME Mary A. Waters

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow  
(Write the word)

DATE OF DEATH Jan 14, 1917  
(Month) (Day) (Year)

DATE OF BIRTH Sept 17 1833  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6, 1917, to Jan 13, 1917, that I last saw her alive on Jan 13, 1917, and that death occurred, on the date stated above, at 10 m.  
The CAUSE OF DEATH\* was as follows:  
1. 1

AGE 83 yrs. 3 mos. 27 ds.  
IF LESS than 1 day, hrs. or min.?

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

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

(Duration) ✓ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (SECONDARY) (Duration) ✓ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PARENTS  
NAME OF FATHER John Stickels  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky  
MAIDEN NAME OF MOTHER Sallie Kiskel  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

(Signed) \_\_\_\_\_ M. D.  
(Address) W. M. Ryland  
\*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Margie Deat  
(ADDRESS) Gorin Ind

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 \_\_\_\_\_

Filed Jan 15, 1917, S. E. Doss  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Gorin Cemetery DATE OF BURIAL Jan 15, 1917  
UNDERTAKER North & Beckett ADDRESS Wyaconda Mo

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*, *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*, *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," "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.)

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

## 1 PLACE OF DEATH

County

Clark

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

CERTIFICATE OF DEATH

Township

Registration District No.

194

File No.

Village

Primary Registration District No.

4117

Registered No.

2

City

Myacunda

(NO.

St.

Ward)

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

## 2 FULL NAME

Mary A. Waters

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

X

W

W

6 DATE OF BIRTH

(Month)

(Day)

1

(Year)

7 AGE

If LESS than  
1 day.....hrs.  
or.....min.?

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)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME  
OF MOTHER13 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

(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:

Erysipelas

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Infectious

(Duration)

yrs.

mos.

ds.

(Signed)

Jaw 14

191

(Address)

Myacunda, 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

Original file, date....., 19.....

JAN 1917

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]

500

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