

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

**1 PLACE OF DEATH**

County Bates  
Township Mound  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. 47 File No. 4607  
Primary Registration District No. 5071 Registered No. 5

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

**2 FULL NAME** Mabel Wilson

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3 SEX** female **4 COLOR OR RACE** white **5 SINGLE MARRIED WIDOWED OF DIVORCED** single  
(Write the word)

**16 DATE OF DEATH** Feb - 20 1917  
(Month) (Day) (Year)

**6 DATE OF BIRTH** Feb 18 1917  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, that I attended deceased from Feb 18 1917 to Feb 21 1917, that I last saw her alive on Feb 20 1917, and that death occurred, on the date stated above, at 6 pm.

**7 AGE** ..... yrs. .... mos. 3 ds. If LESS than 1 day, .... hrs. or .... min.?

The CAUSE OF DEATH\* was as follows:  
108  
Influenza  
(Duration) ..... yrs. .... mos. 3 ds.

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

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

**9 BIRTHPLACE** (City or town, State or foreign country) Adrian, Mo.

(Signed) F. J. Bates M. D.  
Feb 21 1917 (Address) Adrian

**10 NAME OF FATHER** William D Wilson

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

**11 BIRTHPLACE OF FATHER** (City or town, State or foreign country) Oceola Mo

**18 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients, or Recent Residents)

**12 MAIDEN NAME OF MOTHER** Verla Hall

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

**13 BIRTHPLACE OF MOTHER** (City or town, State or foreign country) Kansas

Where was disease contracted if not at place of death?

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Chas J. Wilson  
(Address) Butler Mo.

Former or usual residence

**15**  
Filed 2-20 1917 D. H. W. Luetke  
Registrar

**19 PLACE OF BURIAL OR REMOVAL** Mt Olivet **DATE OF BURIAL** Feb 21 1917

**20 UNDERTAKER** Frank Brown **ADDRESS** Adrian 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*, *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) *Colton 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, 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.)

OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 47

File No. ....

Primary Registration District No. 5071

Registered No. 5

(NO. ....

St. ....

Ward) ....

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

2 FULL NAME

Mabel Wilson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
6 DATE OF BIRTH		
(Month) (Day) (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)		
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)	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21 1917  
(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 St. Louis m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia  
Sup. Lobar  
3  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Admission  
(Duration) yrs. mos. ds.  
Admission M. D.  
Admission (Address) Admission

SUPPLEMENTARY CERTIFICATE

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

\*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 Admission .....

15 Filed 2/20 1917 J. H. W. Little Registrar

19 PLACE OF BURIAL OR REMOVAL Admission DATE OF BURIAL 191

20 UNDERTAKER J. S. Burman ADDRESS Admission 710

Original file, date. FEB 1917, 19.....

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

# States Standard Certificate of Death

Approved by U. S. Census and American Public Health  
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