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

**1 PLACE OF DEATH**

County Scott

Township ~~Sikeston~~ Richland Registration District No. 821 File No. 8728

or

Village ..... Primary Registration District No. 6070 Registered No. 19

or

City ..... (NO. ....., ..... St.; ..... Ward)

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

**2 FULL NAME** Fredrica, Charlotta, Gallian

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb 7 (Month) (Day) 1847 (Year)

7 AGE: 70 yrs. 5 mos. 22 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Salina Co. Illinois

PARENTS

10 NAME OF FATHER: Julius Tiedman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Foren

12 MAIDEN NAME OF MOTHER: Mary N. Miller

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Gallian

(Address) Sikeston Mo

15 Filed 3/10, 1917 W. E. Dennis Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Feb (Month) 7 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 1, 1917, to Feb 7, 1917, that I last saw her alive on Feb 7, 1917, and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Spine

Several years (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Myfield M. D.

Feb 7, 1917 (Address) Sikeston 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: Sikeston Mo

DATE OF BURIAL: 2-10, 1917

20 UNDERTAKER: J. B. Robertson

ADDRESS: Sikeston Mo

# Revised United States Standard Certificate of Death

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

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**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 "*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.)

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

1 PLACE OF DEATH

County Scott

Township Richland
or
Village
or
City (NO. St. Ward)

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

Registration District No. 821 File No.

Primary Registration District No. 6070 Registered No. 19

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

2 FULL NAME Fredrica Charlotta Gallian

SUPPLEMENTARY

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX F

4 COLOR OR RACE W

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

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE yrs. mos. ds.

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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed 3/10, 1917 W. E. Ferris Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH 2/7, 1917 (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:

Pneumonia Bronchial

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of spine

(Duration) yrs. mos. ds.

(Signed) A A Mayfield M. D.

2-7, 1917 (Address) Lipeston, 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

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]

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