

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

1 PLACE OF DEATH

County De Kalb
Township Sheridan
Village
City

Registration District No. 257 File No. 14301
Primary Registration District No. 5361 Registered No. 6
(NO. St. Ward)

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

2 FULL NAME Margaret Henderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

6 DATE OF BIRTH April 17 1837
(Month) (Day) (Year)

7 AGE 79 yrs 11 mos 25 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) +

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

PARENTS
10 NAME OF FATHER William Rodgers
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana.
12 MAIDEN NAME OF MOTHER Nancy Todd.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth F. Sherard
(Address) Clarkdale Mo.

15 Filed 4.16th 1917 J. J. Arnold Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 6 1917 to April 14 1917 that I last saw her alive on April 14 1917 and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage,

(Duration).....yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) (Duration).....yrs.mos.ds.
(Signed) Ch. Albee M. D. April 14, 1917 (Address) Cosby 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 Function Cemetery DATE OF BURIAL 4 17 1917
Downs

20 UNDERTAKER J. J. Arnold ADDRESS Manville 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, 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, 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.)

1 PLACE OF DEATH
 County DeKalb
 Township Sherman
 or
 Village
 or
 City

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

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 hospital or institution,
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 of street and number.)

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PERSONAL AND STATISTICAL PARTICULARS

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

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

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

8 OCCUPATION
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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 4/16 1917 J. T. Arnold
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
 (Month) Apr 14, 1917
 (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
 1917 to 1917
 that I last saw h..... alive on..... 1917
 and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:
Cerebral Neurotoxic
64
 (Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) B. L. Allen M. D.
Apr 14 1917 (Address) Barby Mo.

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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

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 1917

20 UNDERTAKER ADDRESS

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