

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Mo  
Township Shelton  
or  
Village  
or  
City Hurdland (NO. .... St. .... Ward)

Registration District No. 1929

File No. 27 19106

Primary Registration District No. 5602

Registered No. 27

2 FULL NAME

Sarah Catharine Bowling

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH March 23 1840  
(Month) (Day) (Year)

7 AGE 77 yrs. 1 mos. 17 ds. If LESS than 1 day, .... hrs. or .... min.?

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

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

PARENTS  
10 NAME OF FATHER Robert Howerton  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky  
12 MAIDEN NAME OF MOTHER Wm  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wm

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) F. M. Holman  
(Address) Hurdland Mo

15 Filed May 14 1917 D. L. Howerton  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 10 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 5 1917, to May 10 1917, that I last saw her alive on May 10 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH\* was as follows:  
Measles

(Duration) .... yrs. .... mos. 6 ds.

CONTRIBUTORY (Secondary) Measles

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

(Signed) L. H. M. D.  
May 10 1917 (Address) Wm

\*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? Home

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wm DATE OF BURIAL May 10 1917

20 UNDERTAKER Novelly ADDRESS 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, 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.)

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## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

## 1 PLACE OF DEATH

County

Township

or

Village

or

City

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO

St.

Ward)

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

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

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)

PARENTS

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 May 14 1917

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

1917 (Year)

17

I HEREBY CERTIFY, that I attended deceased from

1917, to

1917

that I last saw him alive on 1917  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

M. D.

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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

20 UNDERTAKER

ADDRESS

Original file, date, 1917

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

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9106  
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