

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

PLACE OF DEATH
County Laclede
Township Gasconade
or
Village
or
City

Registration District No. 45-3 File No. 19113
Primary Registration District No. 5-619 Registered No.
City (NO. _____) St. _____ Ward _____

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

FULL NAME Mapes Wilson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
(If wife the word) #2
DATE OF BIRTH Nov 17, 1898
(Month) (Day) (Year)
AGE 17 yrs. 7 mos. 12 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Ray Co

PARENTS
NAME OF FATHER Jas Gowen
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind
MAIDEN NAME OF MOTHER Sallie Hatfield
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ray Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Gowen
(ADDRESS) 21 also

Filed May 31, 1917 G D Hartley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 30, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 29, 1917, to May 30, 1917, that I last saw her alive on May 29, 1917, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Eclampsia

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

Contributory (SECONDARY) Wema
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) F A Hamelton M. D.
May 30, 1917 (Address)

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

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

PLACE OF BURIAL OR REMOVAL Bingham Cemetery DATE OF BURIAL 4, 1917

UNDERTAKER Jas Gowen ADDRESS 21 also

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO _____
 Registration District No. _____
 Primary Registration District No. _____

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

File No. _____
 Registered No. _____

[If death occurred in hospital or institute give its NAME inside of street and number]

St.: _____ Ward)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If fit the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day _____ hrs. or _____ min.?

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

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

NAME OF FATHER _____

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____ 191_____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

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 _____
 The CAUSE OF DEATH* was as follows:

Contributory
 (secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D.

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

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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Laclede
 Township Gasconade
 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. 453 File No.

Primary Registration District No. 5619 Registered No.

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

2 FULL NAME

Mapes Wilson

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 May 31 1917 Registrar J. D. Hartley

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30 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

The CAUSE OF DEATH* was as follows:
Eclampsia
Acute Nephritis
 (Duration) yrs..... mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia (Duration) yrs..... mos. 3 ds. (Signed) A. A. Hamelt M. D. May 30 1917 (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

19 PLACE OF BURIAL OR REMOVAL Covey Cemetery DATE OF BURIAL May 31 1917

20 UNDERTAKER Jas. Roberts ADDRESS Haleson

Satisfactory Information Supplied

Supplementary Certificate

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

1913

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, 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), *29ds.*; *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.)