

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

PLACE OF DEATH

County Barton  
Township Lamar  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 40 File No. 21252

Primary Registration District No. 5058 Registered No. 26

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

FULL NAME Mary Jane Covitzger

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widow  
(Write the word)

DATE OF BIRTH 2 26 1836  
(Month) (Day) (Year)

AGE 81 3 6 If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?  
yrs. mos. ds.

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 6 2 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 28<sup>th</sup>, 1917, to June 2, 1917, that I last saw her alive on May 28, 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage

82-A  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. Walker M. D.  
Lamar Mo 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 no DATE OF BURIAL June 2, 1917  
Lake Cemetery Lamar

UNDERTAKER no ADDRESS Lamar Mo  
Boyd Humphrey

BIRTHPLACE (City or town, State or foreign country) Randolph Co Ill

PARENTS NAME OF FATHER Wm. Brasley  
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown  
MAIDEN NAME OF MOTHER unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Covitzger  
(ADDRESS) Lamar Mo

Filed June 2, 1917, Boyd Humphrey REGISTRAR  
Lamar

**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, 8 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), *20 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

*Barton*

Township

*Lamar*

or

Village

or

City

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

Registration District No.

*40*

File No.

Primary Registration District No.

*5058*

Registered No.

*26*

(NO.

St.

Ward)

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

2 FULL NAME

*Mary Jane Erilsizer*

## 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

1

(Month)

(Day)

(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)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

*June 2, 1917*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June 2*  
(Month)*1917*  
(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

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage.*

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

*E. D. White*

M. D.

*June 2, 1917*

(Address)

*Lamar, 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

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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