

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

1 PLACE OF DEATH  
County Howard  
Township Monteau or Village or City  
Registration District No. 382 File No. 6  
Primary Registration District No. 5331 Registered No. 31722  
(NO. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)  
2 FULL NAME Rachel Lewis  
[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 Black 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

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

7 AGE 45 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) Howard Co

PARENTS

10 NAME OF FATHER James Barrett

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Howard Co

12 MAIDEN NAME OF MOTHER Mary Alexander

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Howard Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jessie Lewis  
(Address) P. O. Box 201, m

15 Filed \_\_\_\_\_, 191\_\_\_\_ Registrar \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Sept \_\_\_\_\_, 191\_\_\_\_  
(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 \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Was not attended by any physician. Subject to Epileptic Convulsion & Discharge. A Convulsion  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) Epilepsy  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. R. Champion M. D.  
Sept 7, 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 Howard Co DATE OF BURIAL Sept 26, 191\_\_\_\_

20 UNDERTAKER Jessie T. Hally ADDRESS Fayette

# 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 child-birth 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.)

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

CERTIFICATE OF DEATH

Township MonteauRegistration District No. 382

File No. ....

Village .....

Primary Registration District No. 5531

Registered No. ....

City .....

(NO. ....

St. ....

Ward) .....

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

2 FULL NAME

Rachel Lewis

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

F.

4 COLOR OR RACE

B5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)M

16 DATE OF DEATH

Sept7, 1917

(Month)

(Day)

(Year)

6 DATE OF BIRTH

(Month)

(Day)

(Year)

7 AGE

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

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:

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).....

CONTRIBUTORY

(Secondary).....

(Duration).....

yrs.....

mos.....

ds.....

(Signed) JR Champion

M. D.

Sept 10, 1917(Address) Rockeast 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

Filed Sept 10, 1917JR Champion  
Registrar

Original file, date....., 19.....

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

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