

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

1 PLACE OF DEATH

County Routledge  
Township St. Francois  
or  
Village ✓  
or  
City ✓ (NO. .... St. .... Ward)

Registration District No. 990 File No. 37589  
Primary Registration District No. 5733 Registered No. 21

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

2 FULL NAME

Margaret Odiline Bennett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>July</u> (Month) <u>17</u> (Day) <u>1887</u> (Year)		
7 AGE <u>30</u> yrs. <u>3</u> mos. <u>21</u> ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Wife</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>House work</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Wayne Mo</u>		
PARENTS	10 NAME OF FATHER <u>Thomas R. Bennett</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	12 MAIDEN NAME OF MOTHER <u>Margaret Irindwell</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
11 (Month) 8 (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10, 6, 1917, to 11 - 7, 1917, that I last saw her alive on 11 - 5, 1917, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH\* was as follows:

238 Tuberculosis of both lungs  
25

28 about 3 yrs. - mos. - ds.  
(Duration)

CONTRIBUTORY Consumption of bowels  
(Secondary)  
(Duration) yrs. 1 mos. 20 ds.  
(Signed) M. J. Halliday M. D.  
11, 8, 1917 (Address) Chassia 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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leah W. Bennett  
(Address) Chassia Mo

19 PLACE OF BURIAL OR REMOVAL <u>Bennett Cem</u>	DATE OF BURIAL ....., 1917
20 UNDERTAKER <u>none</u>	ADDRESS <u>✓</u>

15 Filed 11-13, 1917. J. A. Bryant M.D.  
Registrar

# 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*, *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) *Colton 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 Butler  
 or  
 Township St. Francois  
 or  
 Village  
 or  
 City

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

Registration District No. 990 File No.  
 Primary Registration District No. 5133 Registered No. 21  
 (NO. St. Ward)

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

## 2 FULL NAME

Myrtal Adeline Bennett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE w 5 SINGLE m  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

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

7 AGE  
 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)

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 1-12-1917 JA Bryant M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11-8 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..... m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)  
 (Duration) yrs. mos. ds.

(Signed)..... M. D.

..... 191..... (Address)

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

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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

Bennett Corn 11-9 1917

20 UNDERTAKER ADDRESS

# Revised United States Standard Certificate of Death

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

37589

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