

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

1 PLACE OF DEATH

County Jasper
Township.....
or
Village.....
or
City Somerville (NO..... St.:..... Ward)

Registration District No. 416
Primary Registration District No. 4248

File No. 38606
Registered No. 35

2 FULL NAME Laura Mottley

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
6 DATE OF BIRTH <u>Nov 24 1845</u> (Month) (Day) (Year)		
7 AGE <u>72 yrs 11 mos 10 ds.</u>		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work..... <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9 BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		
PARENTS	10 NAME OF FATHER <u>Charles Hayne</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	12 MAIDEN NAME OF MOTHER <u>Winters</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Nov 4 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 11 1917, to Nov 3 1917, that I last saw her alive on Nov 3 1917, and that death occurred, on the date stated above, at 30.9 m.

18 CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
92 F.
17
(Duration) 4 yrs 2 mos 4 ds.

CONTRIBUTORY (Secondary)
(Duration)..... mos..... ds.
(Signed) J. J. Boy M. D.
Nov 3 1917 (Address) Somerville, 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) Martha Mottley
(Address) Parcepsia mo.

Nov 5 1917 Leroy Simmons
Registrar

19 PLACE OF BURIAL OR REMOVAL <u>Indian Run Church</u>	DATE OF BURIAL <u>11 - 5 1917</u>
20 UNDERTAKER <u>H. C. Spencer</u>	ADDRESS <u>Somerville mo</u>

Information furnished is to be used for statistical purposes only. It is not to be published in any form without the consent of the Missouri State Board of Health. This information is to be kept confidential and is not to be used for any other purpose.

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) *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*; *Broncho-pneumonia* ("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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH

County Jasper Registration District No. 416 File No. _____
 Township _____ or _____ Village _____ or _____ City Sarcoxie (NO. _____) St. _____ Ward _____
 Primary Registration District No. 4248 Registered No. 35

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

2 FULL NAME Sarah Motley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 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) _____

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 Jan 10 1917 Leroy Simmons Registrar
 16 File _____

MEDICAL CERTIFICATE OF DEATH

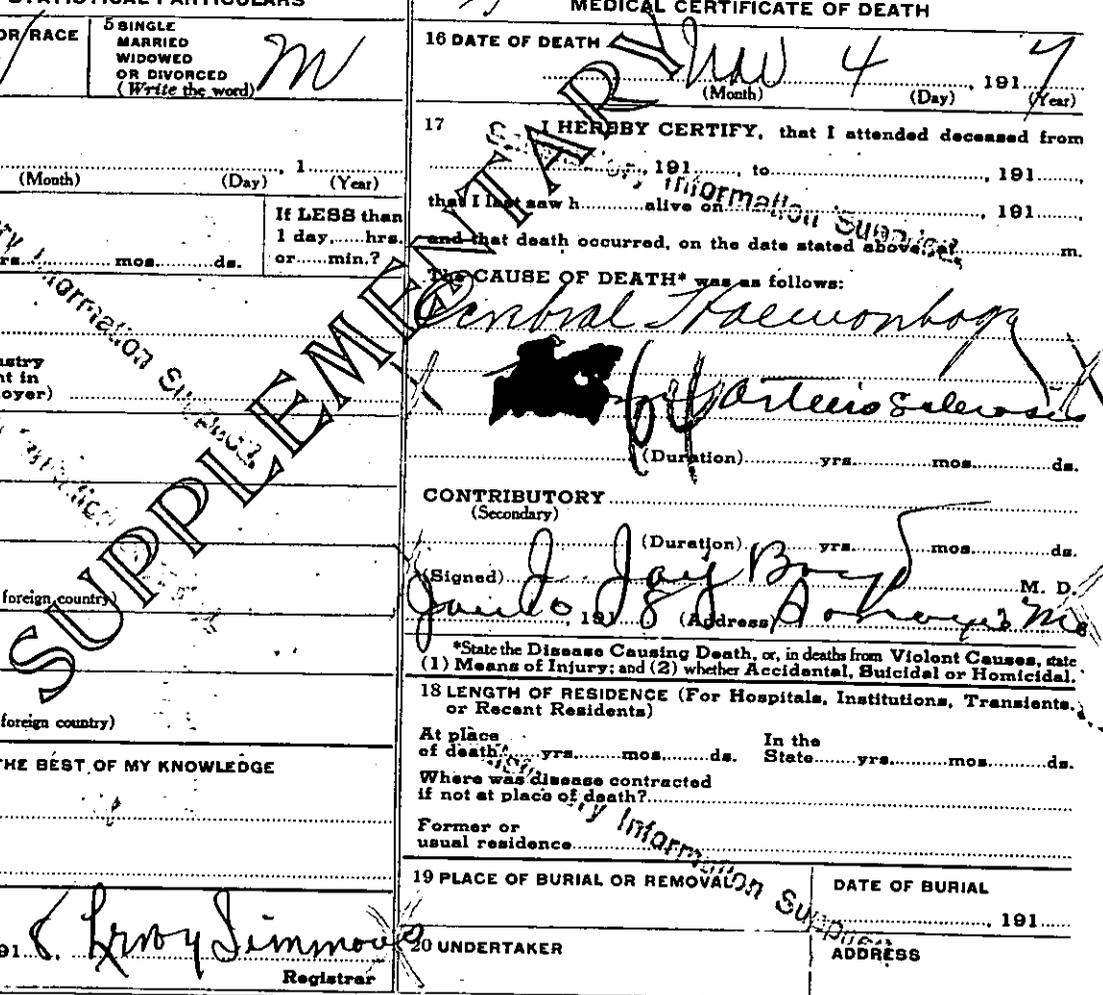
16 DATE OF DEATH _____ (Month) 4 (Day) _____ (Year) 7
 17 I HEREBY CERTIFY, that I attended deceased from _____ of, 1917, to _____, 1917, that I last saw him _____ alive on _____, 1917, and that death occurred, on the date stated above, at _____ m.

CAUSE OF DEATH* was as follows:
Central Pneumonia
of bacterial origin
 (Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Guilo Jay Boy M. D.
 1917 (Address) Doboy, 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 _____ 1917
 20 UNDERTAKER _____ ADDRESS _____



Original file, date Nov 5, 1917

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

N. B.—Every item on this form should be fully supplied. AGI should be stated EXACTLY. Do not state "died" without stating "cause of death".
 1917-1918
 1919-1920
 1921-1922
 1923-1924
 1925-1926
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 2093-2094
 2095-2096
 2097-2098
 2099-2100

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

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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 inter-current) 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 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.)