

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

1 PLACE OF DEATH
County Monroe
Township Union
Village
City (NO. St. Ward)

Registration District No. 580 File No. 38905
Primary Registration District No. 5779 Registered No. 11

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

2 FULL NAME Gertrude A. Riley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word) M

6 DATE OF BIRTH Aug 14 1845
(Month) (Day) (Year)

7 AGE 72 yrs 2 mos 27 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed (or employer) 92A

9 BIRTHPLACE (City or town, State or foreign country) Virginia

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Nov 11 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 12 1917 to Nov 11 1917 that I last saw her alive on Nov 11th 1917 and that death occurred, on the date stated above, at 10 o'clock a.m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular disease of heart (Mitral Insufficiency)
(Duration) 15 yrs 11 mos 11 ds.

PARENTS

10 NAME OF FATHER Geo. Harris

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

12 MAIDEN NAME OF MOTHER Carr

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

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

(Signed) O. B. Davis M. D.
Nov 12, 1917 (Address) Madison Mo. R#5

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Brashers
(Address) Clark 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.

15 Filed Nov 13 1917 E. P. Stovall Registrar

19 PLACE OF BURIAL OR REMOVAL Patton Chapel Cemetery DATE OF BURIAL 1917
20 UNDERTAKER Fred B. Thompson ADDRESS

CAUSE OF DEATH in print terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County

Township

or
Village

or
City

Registration District No.

Primary Registration District No.

File No.

Registered No.

(If death occurred in hospital or by give its NAME of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

4 COLOR OR RACE

6 DATE OF BIRTH 191... (Month) 191... (Day) 191... (Year)

7 AGE 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)

16 DATE OF DEATH 191... (Month) 191... (Day) 191... (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 U.S.C. No.

The CAUSE OF DEATH* was as follows:

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)

CONTRIBUTORY (Secondary) yrs. mos. ds.

(Signed) (Duration) yrs. mos. ds.

..... 191... (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

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)

(Address)

15 Filed 191... Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191... ADDRESS

20 UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

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

Township *North*
or
Village *Wesson*

Registration District No. *5-80*
Primary Registration District No. *5-739*

File No.
Registered No. *11*

(NO. St. Ward)

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

FULL NAME *Gorgie A. Riley*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 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)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER *Lucy Carr*

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed *Jan - 28 - 1918*

E. C. Brock
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 11 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

1917 to 1917

that I last saw him alive on 1917

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.

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

DATE OF BURIAL

1917

20 UNDERTAKER

ADDRESS

File, date, 19.....

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]

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);

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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.)