

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

1 PLACE OF DEATH

County Lafayette

Township \_\_\_\_\_  
or \_\_\_\_\_

Village \_\_\_\_\_  
or \_\_\_\_\_

City Wellington (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 469

File No. 41887

Primary Registration District No. 4779

Registered No. 16

2 FULL NAME Elizabeth Evaline Forster

[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 White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 1 1896  
(Month) (Day) (Year)

7 AGE 61 yrs. 9 mos. 15 ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Thamesford, Ont.

10 NAME OF FATHER John Pokus

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

12 MAIDEN NAME OF MOTHER Lillias Ingram

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. M. Forster (Address) Wellington, Mo.

15 Filed Dec 17 1917 F. W. Munn Registrar

7 MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Dec 16 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 25 1917, to Dec 16 1917, that I last saw her alive on Dec 16 1917, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH\* was as follows:  
Influenza  
72 A  
11 B (Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza (Duration) yrs. mos. ds.  
(Signed) J. C. Munn, M.D. Dec 17 1917 (Address) Wellington, 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 Canada DATE OF BURIAL Dec 16 1917

20 UNDERTAKER Ernest Foyert ADDRESS Wellington, Mo.

K-THIS IS A PERMANENT RECORD

PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. Plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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, 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.)

PERMANENT RECORD  
WRITE PLAINLY, WITH UNFRAID GIN

N. B.—Every item of Inform CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state exact date, if possible, and be classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH  
 County Lafayette  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_ or \_\_\_\_\_  
 City Wellington (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 466 File No. \_\_\_\_\_  
 Primary Registration District No. 4279 Registered No. 16

2 FULL NAME Elizabeth E. Foster

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX L 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED W  
 (Write the word)

6 DATE OF BIRTH \_\_\_\_\_  
 (Month) (Day) (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)

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) \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16 7  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191\_\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_\_,  
 that I last saw him \_\_\_\_\_ 191\_\_\_\_\_,  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 The CAUSE OF DEATH\* was as follows:  
 \_\_\_\_\_  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 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.

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 Removed to Lexington Mo DATE OF BURIAL Dec 15 1917  
 20 UNDERTAKER Ernest J. Jorgens ADDRESS Lexington Mo

SUPPLEMENTARY CERTIFICATE

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (Address) \_\_\_\_\_

15 Filed Dec 17 1917 W. M. Mann  
 Registrar

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

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