

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

1 PLACE OF DEATH

County Stoddard

Township.....

or Village 1

or City Heester (NO..... St. .... Ward)

Registration District No. 838

File No. ....  
Registered No. 43628

Primary Registration District No. 4509

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

2 FULL NAME Sindia Jane Webb

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Single  
(Write the word)

16 DATE OF DEATH December 21 1917  
(Month) (Day) (Year)

6 DATE OF BIRTH June 12 1898  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec-19 1917 to Dec-21 1917, that I last saw her alive on Dec-21 1917, and that death occurred, on the date stated above, at 6 a.m. The CAUSE OF DEATH\* was as follows:

7 AGE 19 yrs. 11 mos. 22 ds. If LESS than 1 day, hrs. or min.?

Peritonitis  
117  
23 (Duration) yrs. mos. 4 ds.

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

CONTRIBUTORY metritis (Secondary) (Duration) yrs. mos. 5 ds.

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

(Signed) Geo. M. Vernon M. D. Dec-21 1917 (Address) Heester - mo

10 NAME OF FATHER Willis Webb

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

11 BIRTHPLACE OF FATHER Heester - mo

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

12 MAIDEN NAME OF MOTHER Sindia Mattingly

At place of death yrs. mos. ds. In the State yrs. mos. ds.

13 BIRTHPLACE OF MOTHER mo

Where was disease contracted if not at place of death?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. H. Webb (Address) Heester

Former or usual residence.....

15 Filed 1-10 1918 J. H. Craig Registrar

19 PLACE OF BURIAL OR REMOVAL Heester lawn DATE OF BURIAL 12-22 1917

20 UNDERTAKER C. C. Briggs ADDRESS Heester, Mo

# 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 "*Asithenia*," "*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 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.)

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

1 PLACE OF DEATH  
 County St. Louis  
 Township .....  
 or  
 Village Dexter  
 or  
 City Dexter (NO. .... St. Ward)

Registration District No. 838 File No. 43628

Primary Registration District No. .... Registered No. ....

2 FULL NAME

Scidnia Jane Webb

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year) ..... 1

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 Filed 6-10 1918 J. L. Crary Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31 1918 (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 .....

The CAUSE OF DEATH\* was as follows: Lentonitis  
She had suffered since a girl with  
braggle & painful menstruation  
more any local treatment  
 (Duration) ..... yrs. .... mos. .... ds.

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

(Signed) G. M. Wilson M. D. May 30 1918 (Address) Dexter Mo

\*Sign 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 .....

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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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 intercurrent) 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.)

ADDRESS

NAME OF SURVIVOR