

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

1 PLACE OF DEATH  
Buchanan  
County.....  
Township.....  
or  
Village.....  
or  
City St. Joseph

Registration District No. 85  
Primary Registration District No. 1001  
(No. 2307 Faron St. Ward)

File No. 7941 98  
Registered No. 398

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

2 FULL NAME Mary V.S. Lawrenson

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH October 21, 1912  
(Month) (Day) (Year)

7 AGE 5 yrs. 5 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) St. Joseph, Mo.

PARENTS 10 NAME OF FATHER John Lawrenson 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Utah 12 MAIDEN NAME OF MOTHER Mary J. Johnston 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John Lawrenson (Address) 2307 Faron St. City

15 Filed March 27, 1918 H. S. Lamate Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 24, 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 23, 1918, to March 24, 1918, that I last saw her alive on March 24, 1918, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:  
Comminution - Broncho Pneumonia  
10 7/8 (W) Whooping Cough  
11 2 11  
(Duration) 4 yr. 10 mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition, Chronic Eczema & Asthma (Duration) 5 yrs. 5 mos. 3 ds. (Signed) Clarence A. Good M. D. March 25, 1918 (Address) St. Joseph, Mo.

\*State the Disease Causing Death, or, in death 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 Mt. Mora Cemetery DATE OF BURIAL Mar. 25, 1918

20 UNDERTAKER Rock ADDRESS 916 Fred. AVE

# 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) *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 "Asthemia," "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 BuchananREGISTRARS 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.....

Registration District No. 85

File No. ....

or

Village.....

Primary Registration District No. 1001Registered No. 398

or

City St. Joseph(NO. 2307 Farm St. ....

Ward) .....

[If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME Mary V. S. Lawrence

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word) S.6 DATE OF BIRTH  
..... (Month) ..... (Day) 1 ..... (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 Filed Mar 29 8 1918 St. Joseph, Mo.  
Registrar Rock

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 24 8  
..... (Month) ..... (Day) ..... (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..... m.

The CAUSE OF DEATH\* was as follows:

.....  
(Duration)..... yrs. .... mos. .... ds.CONTRIBUTORIAL  
(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. 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 Mar 25 191820 UNDERTAKER  
Rock ADDRESS 916 Fred Ave

Original file, date....., 19.....

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

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[Approved by U. S. Census and American Public Health  
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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 "Asthemia," "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.)