

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly 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 Greene  
Township.....  
or  
Village.....  
or  
City Springfield

Registration District No. 318 File No. 8594  
Primary Registration District No. 2001 Registered No. 106  
NO. 935 Procter St. .... Ward

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

**2 FULL NAME** Mary Jane Roach

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3 SEX female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)

16 DATE OF DEATH March 2nd 1918  
(Month) (Day) (Year)

6 DATE OF BIRTH Unknown, past 60.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 16, 1914, to March 2, 1918.

7 AGE Past 60 yrs. .... mos. .... ds. IF LESS than 1 day.....hrs. or.....min.?

that I last saw her alive on March 2, 1918, and that death occurred, on the date stated above, at 12, 2002m

The CAUSE OF DEATH\* was as follows:

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

92.7 Paralysis  
82.0  
(Duration) ..... yrs. .... mos. .... ds.

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

CONTRIBUTORY (Secondary) .....

10 NAME OF FATHER Unknown

(Signed) Dr. Jomar Moore M. D.  
3/2, 1918 (Address) 935 Procter

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

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

12 MAIDEN NAME OF MOTHER Unknown

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

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) Dr. Jomar Moore  
(Address) 935 Procter Springfield Mo

Where was disease contracted if not at place of death? .....

Former or usual residence .....

15 **MAR 3 1918**  
Filed....., 1918 Geo J. James Registrar

19 PLACE OF BURIAL OR REMOVAL Hazelwood Cem DATE OF BURIAL Mar 3, 1918

20 UNDERTAKER W. H. Longner & Co ADDRESS 424 E. Carl

# 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); *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.)

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

1 PLACE OF DEATH  
 County Green

Township or Village or City Springfield

Registration District No. 318

File No. ....

Primary Registration District No. 2001

Registered No. 106

(NO. 935 Braxter St., Ward)

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

2 FULL NAME Mary Jane Rosch

PERSONAL AND STATISTICAL PARTICULARS

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

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  
 (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 June 2 1918 Registrar Lawrence

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June - 2 1918  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 1 1918 to June 2 1918, that I last saw him alive on June 1 1918 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:  
Paralysis  
Nemiplegia  
Cerebral Hemorrhage  
 (Duration)..... yrs..... mos..... ds.

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

(Signed) Anna Moor M. D.  
 (Address) 6/21, 1918 Springfield 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 DATE OF BURIAL

20 UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied.  
 SUPPLEMENTARY  
 Satisfactory Information Supplied.

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