

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Pettis
Township Houstonia
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)Registration District No. 665File No. 14192/81004Primary Registration District No. 5883Registered No. 19

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

FULL NAME Rachel Evans

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If rite the word)DATE OF BIRTH Apr 6, 1901
(Month) (Day) (Year)AGE 17 yrs. 5 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Johnston Co.NAME OF FATHER Isaac B. EvansBIRTHPLACE OF FATHER
(City or town, State or foreign country) Jefferson Co.MAIDEN NAME OF MOTHER Nora Maud TannerBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Johnston Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Evans(ADDRESS) Sweet Springs, Mo.Filed 4-16 1918 J. H. Smith, Mod.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 11, 1918
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec 20, 1917, to March 5, 1918, that I last saw her alive on March 5, 1918, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

T.B.A.
Tuberculosis(Duration) ____ yrs. 5 mos. ____ ds.Contributory Family Taint,
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.(Signed) G. L. Parkhurst, M. D.12-4, 1918 (Address) 137 E. 11th, Houstonia

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

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 _____

PLACE OF BURIAL OR REMOVAL Ellis Cemetery, Johnston Co. DATE OF BURIAL 4-13, 1918UNDERTAKER R. C. Vain ADDRESS Houstonia

PLACE OF DEATH

County

Township

or

Village

or

City

(NO

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.

Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

(Month), (Day), (Year)

AGE

..... yrs. mos. ds.
IF LESS than
1 day, hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER.

BIRTHPLACE OF FATHER.

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month), (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

191.....

that I last saw h..... alive on

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)

..... (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.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, yrs. mos. ds. State

ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

191.....

UNDERTAKER

ADDRESS

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

1 PLACE OF DEATH

County Pettis
Township Houstonia
or
Village
or
City

Registration District No. 665 File No.
Primary Registration District No. 5885 Registered No. 19
St.; Ward

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

2 FULL NAME Rachel Evans

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> (Write the word)
6 DATE OF BIRTH <u>Satisfactory Information Supplied</u> In (Month) (Day) (Year)		
7 AGE <u>Satisfactory Information Supplied</u> yrs. mos. ds.		If LESS than 1 day, hrs. 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 <u>191</u> Registrar		

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>Apr 11 1918</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY that I attended deceased from <u>191</u> to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred, on the date stated above, at <u>191</u> .	
The CAUSE OF DEATH* was as follows: <u>Tuberculosis Pulmonary</u>	
(Duration) yrs. mos. ds.	
CONTRIBUTORY <u>Hereditary</u> (Secondary)	
(Signed) <u>C. L. D. Kline</u> 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	DATE OF BURIAL
20 UNDERTAKER	ADDRESS

MISSOURI STATE BOARD OF HEALTH

Satisfactory Information Supplied

Satisfactory Information Supplied

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

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"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 "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.)