

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

PLACE OF DEATH

County Clark

Township Osborne

Village Alexandria

City _____ (NO. _____)

Registration District No. 189

File No. 28967

Primary Registration District No. 5243

Registered No. _____

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

FULL NAME Ellen E. Hill

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Jan 17, 1824
(Month) (Day) (Year)

AGE 94 yrs. 9 mos. 12 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Flomona Ala

PARENTS
NAME OF FATHER J. Mitchell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ala
MAIDEN NAME OF MOTHER Not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Hill
(ADDRESS) Alexandria Mo

Filed Oct 1, 1918 H. F. Rebo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 29, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1918, to Sept 29, 1918, that I last saw her alive on Sept 29, 1918, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Senile Debility
1 154
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) H. F. Rebo M. D.
Oct 11, 1918 (Address) Alexandria Mo

*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 Hills Cemetery DATE OF BURIAL Oct 1, 1918
UNDERTAKER H. F. Rebo ADDRESS Wayland

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

County _____ Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. _____
 or Village _____ St. _____ Ward _____
 or City _____ (NO. _____) _____
 (If death occurred in 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 _____
 (If *fit* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 AGE _____ yrs. _____ mos. _____ ds. _____ or _____ min.?
 If LESS than 1 day, _____ hrs.

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) _____

Filled _____ 191_____ REGISTRAR _____

-MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____
 XER \$ _____
 I HEREBY CERTIFY, that I attended deceased _____
 _____, 191____, to _____, 191____
 that I last saw h_____ alive on _____, 191____
 and that death occurred, on the date stated above, at _____

 The CAUSE OF DEATH* was as follows:

Contributory _____
 (SECONDARY)
 (Signed) _____
 _____ (Address) _____
 *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 _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

Contributory _____
 (SECONDARY)
 (Signed) _____
 _____ (Address) _____
 *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 _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

Contributory _____
 (SECONDARY)
 (Signed) _____
 _____ (Address) _____
 *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 _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
 (Informant) _____

UNDERTAKER _____ ADDRESS _____

Filled _____ 191_____ REGISTRAR _____

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

PLACE OF DEATH

County Clark
Township Armon

Registration District No. 189
Primary Registration District No. 5263

File No.

Registered No.

City (No.) St. Ward)

DECEASED NAME Ellen E. Hill

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word) widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1918

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

AGE OF BIRTH (MONTH, DAY AND YEAR)
YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

THE CAUSE OF DEATH WAS AS FOLLOWS:
..... (duration) yrs. mos. ds.

OCCUPATION OF DECEASED
Trade, profession, or particular kind of work
General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH..... DATE OF

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

WAS THERE AN AUTOPSY.....

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed)....., M. D.
, 19 (Address).....

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

FILED Oct 18 1918 J. S. Rebo REGISTRAR

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States 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

28968
"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Sepsis of lungs, meninges, peritoneum, etc.*, *Melanoma*, *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.