

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

PLACE OF DEATH

County Jasper
Township Joplin
or
Village
of
City Cartersville (NO. _____)

Registration District No. 407
Primary Registration District No. 4741

File No. 34065
Registered No. 58

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

FULL NAME Mrs. Iva Lybarger

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed
DATE OF BIRTH August 7, 1888
(Month) (Day) (Year)
AGE 30 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Cartersville Mo.

PARENTS

NAME OF FATHER Leander Stepple
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
MAIDEN NAME OF MOTHER Jimmie McMonigal
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. R. Stepple
(ADDRESS) Cartersville

Filed 10/30 1918 J. R. Barry REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October 30, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 25, 1918, to Oct. 30, 1918, that I last saw her alive on Oct. 30, 1918, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH¹ was as follows:
Pneumonia
118
108

(Duration) _____ yrs. _____ mos. 2 ds.
Contributory Influenza
(SECONDARY) (Duration) _____ yrs. _____ mos. 0 ds.
(Signed) J. R. Barry M. D.
10/30 1918 (Address) Cartersville, 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 Cartersville Cem DATE OF BURIAL 10/31 1918
UNDERTAKER Webb City Undertaking ADDRESS Webb City

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City..... (NO.....)

Registration District No.

Primary Registration District No.

File 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	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	COLOR OR RACE
DATE OF BIRTH	(Month) (Day) (Year)	IF LESS than 1 day, hrs. or min.?
AGE yrs. mos. ds.	

OCCUPATION
(a) Trade, profession, or business, or establishment in which employed (or employer)
.....
(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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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

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.

Contributory

(SECONDARY)

..... (Duration) yrs. mos. ds.

(Signed).....

..... 191..... (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..... 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

UNDERTAKER

ADDRESS

191.....

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

1. PLACE OF DEATH

County Jasper Registration District No. 407 File No. _____
 Township _____ Primary Registration District No. 4241 Registered No. 58
 City Cartersville (No. _____) St. _____ Ward _____

2: FULL NAME Ira Tubergen

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>W.</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed, (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY, OR TOWN) _____
 (STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____
 FILED 10/30/18 J. P. Berry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 1918

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Roba unimpaired
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. P. Berry, M. D.,
 _____, 19____ (Address)

*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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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, 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," "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 childbirth 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.