

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

41532

1 PLACE OF DEATH  
County Rolla  
Township blay or Village ..... Registration District No. 424 File No. 12  
Primary Registration District No. 5961 Registered No. 80  
City (NO. .... St. .... Ward) .....  
2 FULL NAME Hope H. Hagen [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female  
4 COLOR OR RACE White  
5 SINGLE MARRIED married  
WIDOWED OF DIVORCED (Write the word)  
6 DATE OF BIRTH October 18, 1870  
(Month) (Day) (Year)  
7 AGE 48 yrs. 17 mos. 17 ds. If LESS than 1 day, .... hrs. or .... min.?  
8 OCCUPATION Housewife  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
9 BIRTHPLACE West Virginia  
(City or town, State or foreign country)  
10 NAME OF FATHER Dr. Frank Lethem  
11 BIRTHPLACE OF FATHER W. Virginia  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER Harriet Ripton  
13 BIRTHPLACE OF MOTHER Virginia  
(City or town, State or foreign country)

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 5, 1918  
(Month) (Day) (Year)  
17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to ..... 191.....  
that I last saw h..... alive on ..... 191.....  
that death occurred, on the date stated above, at 12 m.  
The CAUSE OF DEATH\* was as follows:  
presumably heart failure  
9117  
(Duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (Secondary) .....  
(Duration) ..... yrs. .... mos. .... ds.  
(Signed) E. D. Harris, Coroner Rolla County, Mo.  
11-6-1918 (Address) New London, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Thos. S. Hagen  
(Address) Hannibal Mo.

\*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.....

15 Filed Dec 12 8 9 H. Gould 1918  
Registrar

19 PLACE OF BURIAL OR REMOVAL Mt. Clinton DATE OF BURIAL Nov. 7, 1918  
20 UNDERTAKER Wm. M. Smith ADDRESS Hannibal Mo.

# 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, 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 "Asthena," "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 septicæmia," "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.)

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

**1. PLACE OF DEATH**

County Madison Registration District No. 128 File No. ....  
 Township Clark Primary Registration District No. 3461 Registered No. 80  
 City St. Louis St. 19 Ward

**2. FULL NAME**

(a) Residence No. 1012 St. 19 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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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.

**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)

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)

15. FILED Feb 8, 1919 J. H. Gould REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 5 1918

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

THE CAUSE OF DEATH\* AS FOLLOWS:

Essentially heart failure acute endocarditis  
There was (no) physician in attendance

CONTRIBUTORY (SECONDARY) sick about (duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED I was here shortly after his death

IF NOT AT PLACE OF DEATH... DATE OF

DID AN OPERATION PRECEDE DEATH... There was  
 WAS THERE AN AUTOPSY. No indication of  
 WHAT TEST CONFIRMED DIAGNOSIS? Violence

(Signed) J. H. Gould Registrar M. D. (Address) 19

\*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

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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.

41532