

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

8442

1 PLACE OF DEATH

County Pike  
Township North River  
or  
Village  
or  
City Ashburn (NO. 4406 St. 4 Ward)

Registration District No. 682  
Primary Registration District No. 4406

File No. 8442  
Registered No.

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

2 FULL NAME Steve Meyers

PERSONAL AND STATISTICAL PARTICULARS

4 MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

16 DATE OF DEATH Feb 13 1920  
(Month) (Day) (Year)

6 DATE OF BIRTH Feb 7 1896  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 7 1920 to Feb 13 1920, that I last saw her alive on Feb 13 1920, and that death occurred, on the date stated above, at 8 A.M.

7 AGE 24 yrs. 6 mos. 6 ds. If LESS than 1 day.....hrs. or.....min.?

The CAUSE OF DEATH\* was as follows:  
General Peritonitis

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) 15 yrs. 10 mos. 10 ds. (Duration) (Signed) H. L. Cooper M. D. Feb 13 1920 (Address) Ashburn, Mo.

9 BIRTHPLACE (City or town, State or foreign country) Louisiana Mo

PARENTS 10 NAME OF FATHER John Gray 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Clarksville Mo 12 MAIDEN NAME OF MOTHER Mandy Jansetty 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Louisiana Mo.

CONTRIBUTORY Persistent Vomiting (Secondary) (Duration) (Signed) H. L. Cooper M. D. Feb 13 1920 (Address) Ashburn, Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Frank D Meyers (Address) Quincy Ill

\*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 2/15 1920 McGowan Registrar

19 PLACE OF BURIAL OR REMOVAL Prichett County DATE OF BURIAL 2/15 1920 20 UNDERTAKER J. C. Hiley Jr ADDRESS Louisiana Mo

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.

# 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

"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.)

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

**1. PLACE OF DEATH**

County Pike Registration District No. 682 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4406 Registered No. \_\_\_\_\_  
 City Ashburn St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Meyers  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 7 1890  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min. 24 6

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

9. BIRTHPLACE (CITY OR TOWN) Louisiana  
 (STATE OR COUNTRY)

10. NAME OF FATHER Mr. Gray  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Louisiana  
 (STATE OR COUNTRY) Shreveport  
 12. MAIDEN NAME OF MOTHER Amanda Tammert  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ashburn  
 (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. Amanda Street  
 (Address) Ashburn Mo.

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ W. Wheeler  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-13 1920  
 17. I HEREBY CERTIFY, That I attended deceased from Feb \_\_\_\_\_  
8th 1920, to Feb 13 1920,  
 (that I last saw alive on Feb 13 1920), and that death occurred on the date stated above, at \_\_\_\_\_  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma of intestine  
 (duration) 1 yrs. mos. da.

CONTRIBUTORY (SECONDARY) None  
 (duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Quincy, Ill.  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF about 7/10/19

WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS None  
 (Signed) H. L. Cooper M. D.  
 \_\_\_\_\_ 19 \_\_\_\_\_ (Address) Ashburn Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ashburn Mo. DATE OF BURIAL Feb 15 1920

20. UNDERTAKER Frank Haley ADDRESS Louisiana Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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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 gives 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.