

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.

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

1 PLACE OF DEATH

County *Shelby*  
Township *Bethel*  
Village  
City

Registration District No. *826* File No. *18504*  
Primary Registration District No. *4088* Registered No. *5*  
(NO. St. Ward)

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

2 FULL NAME *Mrs Nancy Pepper*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED *widowed*  
(Write the word)

6 DATE OF BIRTH *Oct. 7, 1839*  
(Month) (Day) (Year)

7 AGE *81 yrs 6 mos 21 ds.* If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Marion Co Mo.*

PARENTS  
10 NAME OF FATHER *Samuel Cochran*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Not known*  
12 MAIDEN NAME OF MOTHER *Fannie Cochran*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Not known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Lewis Schreiner*  
(Address) *Bethel Mo.*

15 Filed *May 1, 1920* Registrar *L. L. Smith*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April 27, 1920*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *April 24, 1920* to *April 27, 1920*  
that I last saw her alive on *April 27, 1920*  
and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH\* was as follows:  
*82 A*  
*Cerebral Apoplexy*  
(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) *L. L. Smith* M. D.  
*Apr 27, 1920* (Address) *Bethel 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

19 PLACE OF BURIAL OR REMOVAL *Mt Zion Cemetery* DATE OF BURIAL *May 1, 1920*

20 UNDERTAKER *F. B. Brothers* ADDRESS *Bethel 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 "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.

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