

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

✓ 34914-B

PLACE OF DEATH

County R. Clay Registration District No. 728 File No. 42
Township Clay Primary Registration District No. 5961 Registered No. 111
City (No. _____) St. _____ Ward _____

FULL NAME

Rebecca Jane Marlow

(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

SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

DATE OF BIRTH (MONTH, DAY AND YEAR) _____

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, — hrs. or — min.
<u>77</u>	<u>0</u>	<u>0</u>	<u>0</u>	

OCCUPATION OF DECEASED

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

BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ohio

10. NAME OF FATHER James Martin

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not known

INFORMANT W. O. Whaley
(Address) R R 4 Hannibal Mo

Files 4/15 1930 J. H. Gansel REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/13 19 20

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 1920, to 11-13, 1920 that I last saw her alive on 8-1-20, 1920 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of frontal bone

53 D (duration) 12 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 45 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) P. J. Reichmann, M. D.
11/14, 19 20 (Address) Oakwood Mo.

*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 Salt Lake cemetery DATE OF BURIAL 11-15 19 20

20. UNDERTAKER Tom Smith ADDRESS Hannibal Mo

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....)..... St.....

2. FULL NAME.....

(a) Residence. No..... St.,..... Ward.....
 (Usual place of abode) (If nonresident give city or town)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

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

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..... 19.....
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY..... (SECONDARY).....
 (duration)..... yrs.....

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)....., 19..... (Address).....

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

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

DATE OF BURIAL.....

20. UNDERTAKER.....

ADDRESS.....

PARENTS

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CITY OF ST. LOUIS, MISSOURI

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

1. PLACE OF DEATH
 County Clay Registration District No. 728 File No. _____
 Township Clay Primary Registration District No. 5961 Registered No. 111
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Rebecca Jane Marlow
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) don't know

7. AGE 77 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)

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 11-15-20 of J. H. Gould REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-13-20 1920

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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) _____, 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 Salt creek Cem DATE OF BURIAL 11-15-20
 20. UNDERTAKER Tom M. Smith ADDRESS Hannibal Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE.

RECEIVED BY LAW.

Revised United States Standard Certificate of Death

Approved by U. S. Census and American Public Health
Association.]

34914-B

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"); *Dysphtheria* (avoid use of "Group"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified is indefinite); *Tuberculosis of lungs, meningis, 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), *99 da.*; *Bronchopneumonia* (secondary), *10 da.* 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," "Tremor," "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 undesignable 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

✓ 34914-B

PLACE OF DEATH

County Ralls
Township Clay
City (No.)

Registration District No. 728
Primary Registration District No. 5961

File No. 42
Registered No. 111
St. Ward

FULL NAME

Rebecca Jane Marlow

(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
In 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

SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

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

DATE OF BIRTH (MONTH, DAY AND YEAR)
YEARS 77 MONTHS 0 DAYS 0
If LESS than 1 day, hrs. or min.

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

BIRTHPLACE (CITY OR TOWN) Ohio
STATE OR COUNTRY

NAME OF FATHER Benajah Gustin

BIRTHPLACE OF FATHER (CITY OR TOWN) N. Carolina
STATE OR COUNTRY

MAIDEN NAME OF MOTHER Not known

BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
STATE OR COUNTRY

INFORMANT W. O. Whaley
Address RR 4 Hannibal Mo

FILE 11/15 1920 J. H. Gussel
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/13 1920

17. I HEREBY CERTIFY, That I attended deceased from 11/1 1919, to 11-13 1920
that I last saw h.B.M. alive on 8-1-10 1920 and that death occurred, on the date stated above, at 10 P

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of frontal bone
Duration 12 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 45
(duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH?

DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. J. Reichenauer, M. D.
11/14, 1920 (Address) Cairo Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, 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 Salt Lake cemetery
DATE OF BURIAL 11-15 1920

20. UNDERTAKER Wm. Smith
ADDRESS Hannibal

Item #10 amended by affidavit by Great Grand Daughter 9/3/04 art
Verified by 1850 US Census Bureau Record, Union Twship, Madison Co. Indiana Oct. 9, 1850

