

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

2061

1. PLACE OF DEATH

County Pettis Co Registration District No. 664 File No. _____
 Township Washington Primary Registration District No. 5884 Registered No. 20
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Mary Boneman
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 54 yrs. 6 mos. _____ ds. How long in U.S., if of foreign birth? 54 yrs. 6 mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF
 (OR WIFE OF) Edward Boneman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
54 — 6 = 11

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 employer) General housework
 (c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Cole Camp Mo
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER John D. Harris

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

12. MAIDEN NAME OF MOTHER Katrina Burtch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany

14. INFORMANT John Harris
 (Address) Spring Mo

15. FILED 1/2 19 23 G. R. Shelley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/1 1923
 17. I HEREBY CERTIFY That I attended deceased from 1/1 1923
 to 1-1 1923
 that I last saw her alive on 1/1 1923 and that death occurred, on the date stated above, at 8:40 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
 (duration) 20 min yrs. _____ mos. _____ ds.
 CONTRIBUTORY Art sclerosis
 (SECONDARY) (B.P. 295)
 (duration) 6 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED At POB
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Genl symptoms
 (Signed) B. Frankwinder, M. D.
 (Address) Spring 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 Chase Creek Cem
 (Benton Co) DATE OF BURIAL 1-4-1923

20. UNDERTAKER Ed Euloff
 ADDRESS Cole Camp

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, peritonum, 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.

1 PLACE OF DEATH

664 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS664
5884
STANDARD CERTIFICATE OF DEATHCounty PettisTownship Washington

Village _____

City _____ (No. _____ St.; _____ Ward)

State of _____

Registered No. _____

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

2 FULL NAME Mary Barenan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Th 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M6 DATE OF BIRTH X July 1, 1868
(Month) (Day) (Year)7 AGE 54 yrs. 6 mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) General House Work9 BIRTHPLACE (State or country) Colo Camp Mo.10 NAME OF FATHER John D Harris11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Kathrin Holst13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Harris(Address) Lonia Mo15 Filed Jan 2nd 1923 G. V. Shelly
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1, 1923
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Jan 1st, 1923, that I last saw her alive on Jan 1st, 1923, and that death occurred, on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH* was as follows:

Cerebroplexy

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

Contributory Art Sclerosis
(SECONDARY) B.P. 295(Duration) 6 yrs. _____ mos. _____ ds.(Signed) B. Frank Windle, M. D._____, 191____ (Address) Lonia Mo

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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 Chase Creek Cemetery DATE OF BURIAL Jan 4th, 1923
Fulton Co20 UNDERTAKER Ed Echoff ADDRESS Bab Camp Mo

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