

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

1795

11523

1 PLACE OF DEATH

County Saline  
Township Grand Pass  
or  
Village  
or  
City

Registration District No. 420 File No.  
Primary Registration District No. 6038 Registered No.  
St. Ward

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

2 FULL NAME Lillie A Tolle

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 1 - 18 1898  
(Month) (Day) (Year)

7 AGE 45 yrs 2 mos 9 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Osage Co Kansas

PARENTS  
10 NAME OF FATHER Sam Pelech  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) U  
12 MAIDEN NAME OF MOTHER Nancy Lagan  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) V

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Doctor L. C. Moss  
(Address) Grand Pass Mo

15 Filed 27 1923 Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 27 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 12 1923 to Mar 27 1923, that I last saw her alive on Mar 20 1923 and that death occurred, on the date stated above, at 4 A m.  
The CAUSE OF DEATH\* was as follows:

Acute dilatation of heart (sudden death)  
(Duration) yrs. mos. ds. 11 10

CONTRIBUTORY (Secondary) Syphilis  
(Duration) yrs. mos. ds. 10

(Signed) E. H. Caser M. D.  
Mar 27 1923 (Address) Grand Pass Mo

\*State the Disease Causing Death, or, in death 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 Grand Pass Mo DATE OF BURIAL 3/28 1923

20 UNDERTAKER T. R. Ruedrum ADDRESS Waverly 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. 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.)

# STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

1 PLACE OF DEATH  
 County Saline State MISSOURI Registered No. \_\_\_\_\_  
 Township Grand Pass of Village \_\_\_\_\_  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillie A. Folle  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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.  
(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED W  
(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. of \_\_\_\_\_ 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) house wife  
 (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) unknown

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) unknown

14 Informant \_\_\_\_\_  
(Address)

15 Filed 3-27-23 Geo B. Williams  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 27 19 23

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\* 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTAL

TION is very important. See instructions on back of certificate.

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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.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

11523