

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

Do not use this space.

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**1. PLACE OF DEATH**

County..... Buchanan  
Township.....  
City..... St. Joseph,

Registration District No. 22  
Primary Registration District No. 2730 Penn St.  
City..... St. Joseph, (No. 2730 Penn St.)

File No. 8  
Registered No. 8  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Sarah Larrabee

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Kidder, Mo.

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept, 16, 1844

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>80</u>	<u>3</u>	<u>17</u>	

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Cassioctan Co, Ohio.  
(STATE OR COUNTRY)

10. NAME OF FATHER David Richardson

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

12. MAIDEN NAME OF MOTHER Evelyn Shaffer

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

14. INFORMANT Mrs. J. E. Costello  
(Address) 2730 Penn St.

15. FILED 1/3 20 Ezra Harrison  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan, 3, 1925 1925

17. I HEREBY CERTIFY, That I attended deceased from 1-1-25 to 1-3-25, 1925, that I last saw her alive on Jan 3 - 3 - 25, 1925, and that death occurred, on the date stated above, at 4.40 A.M. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cancer of Pelvis

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

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. H. Francis, M. D.

1/2, 1925 (Address) 714 1/2 Francis St.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kidder, Missouri DATE OF BURIAL Jan, 4, 1925

20. UNDERTAKER W. Meierhoffer ADDRESS 1302 Faraon

Bu J. J. J.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

# 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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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.

requested to make every effort to obtain information, indicated by check marks, lacking from the death certificate:

Name: Sarah Larrabee

Who died at: St. Joseph on Jan 3 - 1925

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Cancer of Pelvis  
(Primary Seat) Malignant

Contributory: \_\_\_\_\_

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

Name of physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_

RECEIVED

MAR 2 - 1924

THE STATE BOARD OF HEALTH OF MISSOURI

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The information is sought for statistical purposes. Prompt return of the information desired will be appreciated. For your reply, an envelope

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