

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

Do not use this space.

13981

**1. PLACE OF DEATH**

County Shelby Registration District No. 828  
Township Jackson Primary Registration District No. 4301  
City Marionville (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

File No. 5  
Registered No. 5

**2. FULL NAME**

Althea Magdeline Roseman

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

6A. IF MARRIED, WIDOWED, OR DIVORCED (or) WIFE OF Wm J Roseman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 - 1904

7. AGE YEARS MONTHS DYS U-LESS than 1 day, hrs. or min.  
21 10 22

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employee)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Marionville  
Shelby Co Mo

10. NAME OF FATHER Wm J Roseman

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

12. MAIDEN NAME OF MOTHER Lyla M. West

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

14. INFORMANT (Address) Thelma Roseman  
Marionville Mo

15. FILED 4-13-25 10:11 P.M. REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 12 1925

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1925, to Apr 12 1925, that I last saw h. or alive on Apr 12 1925, and that death occurred, on the date stated above, at 7 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Asthenia induced by Profound stupor with Babansia 2050  
(duration) yrs. mos. ds. 10 ds.

CONTRIBUTORY (SECONDARY) Hysterectomy + Epilectical Insanity intermittent for life  
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH. Yes DATE OF Feb. 6 1925

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS.  
(Signed) J. H. Hess, D.O. M. D.  
, 19 (Address) Marionville 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 I.O.O.F. Cemetery DATE OF BURIAL 4-14 1925

20. UNDERTAKER J. J. Givay ADDRESS Marionville Mo

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# 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 neoplasma); *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.

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

**1. PLACE OF DEATH**

County Shelby Registration District No. 828 File No. \_\_\_\_\_  
 Township Jackson Primary Registration District No. 45-01 Registered No. 31  
 City Hammawell (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Althea Magdaine Foreman  
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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) \_\_\_\_\_

PARENTS

14.

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15.

FILED \_\_\_\_\_ 19 1925 R. H. Parker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 12 19 25

17. I HEREBY CERTIFY That I attended deceased from Apr 10 1925 to Apr 12 1925 that I last saw her alive on Apr 12 1925, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Asphyxia induced by Profound Stupor with Paranoia

CONTRIBUTORY (SECONDARY) Hysterotomy & Epileptical Insanity - intermittent for years

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb. 6 1925

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) J. H. Hess, D.O. M. D.  
 , 19 (Address) \_\_\_\_\_

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

DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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"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.)

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ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

18651

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

Name: Althea Magaine Foreman

Who died at: Hammewell on Apr 12-1926

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

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

Sex: F 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: Asthenia induced by profound stupor with paranoia

Contributory: Hysterectomy & epileptical insanity  
Hysterectomy performed to relieve Hysteria X

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

Did operation precede death? Yes - Date of Feb-6-1925

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

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

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

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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