

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

PLACE OF DEATH

County Greene
Township Casper
or
Village _____
or
City Stanbery Mo. (NO. _____ St.; _____ Ward)

Registration District No. 314 File No. 18840
Primary Registration District No. 4190 Registered No. 25

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

FULL NAME Bessie Madine Coughlin

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE Single MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH May 13 1925
(Month) (Day) (Year)

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

OCCUPATION (a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE (City or town, State or foreign country) Stanbery Mo

PARENTS
NAME OF FATHER Jerrie E. Coughlin
BIRTHPLACE OF FATHER Lewardswood Kansas
MAIDEN NAME OF MOTHER Gladys White
BIRTHPLACE OF MOTHER Paverwood Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Gladys Coughlin
(ADDRESS) Stanbery Mo

Filed Jan 10 1926 Sue E. Menden
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 20 1925
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at 14 m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
10779

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

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

(Signed) W. A. Crockett M. D. 12/21 1925 (Address) Stanbery Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL Stanbery Mo DATE OF BURIAL 12 21 1925

UNDERTAKER Leroy H. Phillips ADDRESS Stanbery Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

St. _____ Ward _____

(If de-
 hospital
 give in
 of state)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds.
If LESS than
 1 day, _____ hrs.
 or _____ min.?

OCCUPATION _____
 (a) Trade, profession, or business, or establishment in which employed (or employer)
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE _____
(City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attended _____, 191____, to _____ (Month) _____

that I last saw h _____ alive on _____ and that death occurred, on the date stated above
 The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs.

Contributory (SECONDARY) _____ (Duration) _____ yrs.

(Signed) _____ (Address) _____

* State the Disease Causing Death, or, in deaths from Violence, (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs.

Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF _____

UNDERTAKER _____ ADDRESS _____

MISSOURI STATE BOARD OF BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Trustable terms and refuse to accept certificates containing them. This form is used 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, septicaemia, tetanus, typhoid fever, typhus, and venereal diseases."

NOTES

Individual offices may add to above list of und-
 state occupation at de-
 DISEASE CAUSING DEATH, state occupation at de-
 ginning of illness. If retired from business, that
 fact may be indicated thus: Farmer (retired, 6
 yrs.). For persons who have no occupation what-
 ever, write None.

Statement of Cause of Death.—Name, first, the
 disease causing death (the primary affection with
 respect to which the death occurred).

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Gentry Registration District No. 314 File No.
 Township Primary Registration District No. 4190 Registered No. 25
 City Stanberry (No. St. Ward)

2. FULL NAME

Berlah Nadine Coughlin
 (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 8
(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

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 7/4 76 68 Bendt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec, 20 19 25

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia

Purpura (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

1000 (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) As. A. Coughlin, M. D.
7/3, 1925 (Address) Stanberry, 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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MISSOURI STATE BOARD OF HEALTH

SUPPLEMENTARY

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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, 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.; *Broncho-pneumonia* (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.

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