

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

PLACE OF DEATH

County Henry Co
Township Walker
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 355 File No. 34056
Primary Registration District No. 5498 Registered No. 6

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

FULL NAME Catherine Gragg

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX woman COLOR OR RACE White SINGLE ~~MARRIED~~ WIDOWED Widowed
OR DIVORCED
(Write the word)
DATE OF BIRTH Feb 27 24, 1823
(Month) (Day) (Year)
AGE 87 yrs. 9 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Nov 24, 1910
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from Nov 13, 1910, to Nov 27, 1910, that I last saw h alive on Nov 20, 1910, and that death occurred, on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

BIRTHPLACE (City or town, State or foreign country) Green Co Penn.

metastasis of Liver
with Mitral Insufficiency
I was her on 7th day of 13!
my Pres visit (Duration) ___ yrs. ___ mos. 20 ds.

PARENTS
NAME OF FATHER John Cook
BIRTHPLACE OF FATHER (City or town, State or foreign country) England
MAIDEN NAME OF MOTHER Elizabeth Hice
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penn.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Geo Berry M. D. (Address) Montrose

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

*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 _____

Filed Nov 27, 1910, A. W. Graham REGISTRAR

PLACE OF BURIAL OR REMOVAL Stones Chapel DATE OF BURIAL Nov 29, 1910
UNDERTAKER W. L. Lemmatt ADDRESS Montrose

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.

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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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.)



PHYSICIANS should state sex, age, height, weight, occupation, and date of last examination. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state sex, age, height, weight, occupation, and date of last examination. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state sex, age, height, weight, occupation, and date of last examination. Should be carefully supplied. AGE should be stated EXACTLY.

PLACE OF DEATH
 County Henry Co.
 Township Walker

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
 REGISTRATION DISTRICT NO. 355 FILE NO. 34056
 PRIMARY REGISTRATION DISTRICT NO. 5498 REGISTERED NO. 6

City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Catherine Gragg

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

| PERSONAL AND STATISTICAL PARTICULARS | | | | MEDICAL CERTIFICATE OF DEATH | |
|--|--|--|--|------------------------------|--|
| SEX <u>Woman</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED (If rit. <u>widow</u>) | DATE OF DEATH <u>Nov. 27</u> , 191 <u>0</u> (Month) (Day) (Year) | | |
| DATE OF BIRTH <u>Feb. 24</u> , 18 <u>83</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>Nov. 13</u> , 191 <u>0</u> to <u>Nov. 27</u> , 191 <u>0</u> , that I last saw <u>her</u> alive on <u>Nov. 20</u> , 191 <u>0</u> , and that death occurred, on the date stated above, at <u>4:30 p.m.</u> | | |
| AGE <u>87</u> yrs. <u>9</u> mos. <u>3</u> ds. | | If LESS than 1 day, ___ hrs. or ___ min.? | The CAUSE OF DEATH* was as follows: <u>Diagnosis of liver</u> <u>with Mitral insufficiency</u> <u>was her on 7th day of 13</u> <u>my first visit</u> (Duration) <u>7</u> yrs. <u>20</u> mos. <u>20</u> ds. | | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | Contributory (SECONDARY) _____ yrs. _____ mos. _____ ds. (Signed) <u>G. W. Berry</u> M. D. _____ 191_____ (Address) <u>Montrose</u> | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Green Co Tenn</u> | | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal. | | |
| PARENTS | NAME OF FATHER <u>John Cook</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>England</u> | | Where was disease contracted if not at place of death? Former or usual residence _____ | | |
| | MAIDEN NAME OF MOTHER <u>Elizabeth Rice</u> | | PLACE OF BURIAL OR REMOVAL <u>Stones Chapel</u> | | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</u> | | DATE OF BURIAL <u>Nov. 29</u> , 191 <u>0</u> | | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>G. W. Berry</u> X | | | UNDERTAKE <u>Helen party</u> | | |
| (ADDRESS) <u>Montrose, Tenn</u> X | | | ADDRESS <u>Montrose</u> | | |
| Filed <u>Nov 27</u> , 191 <u>0</u> , <u>A. W. Graham</u> REGISTRAR | | | | | |

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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