

PLACE OF DEATH

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

County Henry Registration District No. 356 File No. 28101
 Township Peet Creek or Village _____ Primary Registration District No. 5499 Registered No. 11
 or City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Dora May Massy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE yes ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
 DATE OF BIRTH April 25, 1875 (Month) (Day) (Year)
 AGE 36 yrs. 2 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work none God
 (b) General nature of industry, business, or establishment in which employed (or employer) none

DATE OF DEATH 7 - 1 - 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1911, to July 1st, 1911, that I last saw her alive on June 30, 1911, and that death occurred, on the date stated above, at 1 A. M.
 The CAUSE OF DEATH* was as follows:

Epilepsy

BIRTHPLACE (City or town, State or foreign country) Osage Co., Mo.

(Duration) 30 yrs. ___ mos. ___ ds.

PARENTS
 NAME OF FATHER W. W. Massy
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Texas
 MAIDEN NAME OF MOTHER Kearse
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

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

(Signed) _____ M. D.
 _____ 1911 (Address) _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 _____

(Informant) L. Schmitt
 (ADDRESS) Clinton Mo

PLACE OF BURIAL OR REMOVAL Courts Cemetery DATE OF BURIAL 7-2-1911
 UNDERTAKER W. P. Kitchen ADDRESS Clinton Mo

Filed 8-8- 1911 J. P. Allen REGISTRAR

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.)



PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

County Adair
Township Deer Creek
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 356 File No. 28707
Primary Registration District No. 5499 Registered No. 11

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

FULL NAME Dora May Massy

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>yes</u>
DATE OF BIRTH <u>April 25</u> , 1 <u>875</u> (Month) (Day) (Year)		
AGE <u>36 yrs. 2 mos. 8 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7-1, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from June 28, 1911, to July 1st, 1911, that I last saw her alive on June 30, 1911, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:
Epilepsy

BIRTHPLACE (City or town, State or foreign country) Osage Co. Mo.

PARENTS

NAME OF FATHER <u>W. W. Massy</u>	(Duration) <u>30</u> yrs. ___ mos. ___ ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Texas</u>	Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
MAIDEN NAME OF MOTHER <u>Kear</u>	(Signed) <u>J. P. Allen</u> M. D. <u>July 2nd 1911</u> (Address) <u>Lewis Sta Mo.</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>	*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Schmitt
(ADDRESS) Clinton Mo.

Filed 8-8-11 J. P. Allen REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Combs Cemetery</u>	DATE OF BURIAL <u>7-2</u> 19 <u>11</u>
UNDERTAKER <u>A. P. Kitchen</u>	ADDRESS <u>Clinton Mo.</u>

Revised United States Standard Certificate of Death

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

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