

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.

PLACE OF DEATH

County PlatteTownship Orslev

or

Village _____

or

City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 692File No. 6352Primary Registration District No. 5920

Registered No. _____

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

FULL NAME Elizabeth Jane Heath

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

WhiteSINGLE
MARRIED Widowed
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

July 25, 1899
(Month) (Day) (Year)

AGE

71 yrs. 5 mos. 29 ds.
If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Housekeeper

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

BIRTHPLACE

(City or town, State or foreign country) Ohio

PARENTS

NAME OF FATHER

Geo. Frazier

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Ireland

MAIDEN NAME OF MOTHER

Eleanor Elliott

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Bell Powers(ADDRESS) Learnmouth - Kans.Filed Feb 9, 1912Lucian Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 22, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from rec'd, 1912, to Jan 22, 1912, that I last saw her alive on Jan 22, 1912, and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH was as follows:

General peritonitis121 B122 A129

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Henry H. Patterson M. D.Jan, 1912 (Address) Cedartown, 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

McLomas Cemetery

DATE OF BURIAL

1/24, 1912

UNDERTAKER

Joe M. McLomas

ADDRESS

Edgerton, Mo

PLACE OF DEATH

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

St. _____ Ward _____

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
particular kind of work _____

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

BIRTHPLACE

(City or town,
State or foreign country)

NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

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

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

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.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____, (Month) _____ (Day) _____, 191____ (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 _____ m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

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

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

(Signed) _____

(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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

If not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

4

PLACE OF DEATH

County

Platte

Township

Preston

or

Village

or

City

(NO.

St.

Ward)

FULL NAME

Elizabeth Jane Neath

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

693

File No.

6352

Primary Registration District No.

5920

Registered No.

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

F.

COLOR OR RACE

W.

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Wid.

DATE OF BIRTH

July 25

1839

(Month)

(Day)

(Year)

AGE

71 yrs. 5 mos. 29 ds.

If LESS than
1 day, hrs.
or min.

OCCUPATION

(a) Trade, profession, or
particular kind of work

Housekeeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)

Ohio

PARENTS

NAME OF
FATHER

Geo. H. H. H.

BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

Ireland

MAIDEN NAME
OF MOTHER

Eleanor Elliott

BIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Bell Powers

(ADDRESS)

Leavenworth Kans

Filed

Feb 7

1912

Lecian Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan. 23

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

Dec. 16, 1911, to Jan. 22, 1912

that I last saw her alive on Dec. 11, 1912

and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis
caused by rupture of bowel
following appendicitis

(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Harry H. Patterson

M. D.

Jan 23 1912

(Address) Edgerton 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

McComas Cem.

DATE OF BURIAL

1/24, 1912

UNDERTAKER

Jas. M. McComas

ADDRESS

Edgerton Mo.

Original file, date, 1912

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

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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, 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" (mere y symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "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.)