

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.

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

PLACE OF DEATH Hayward
County Black River
Township Black River Registration District No. 892 File No. 19007
or
Village _____ Primary Registration District No. 6194 Registered No. _____
or
City _____ (No. _____) St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Golden Marie Turner

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>yes</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Not known</u> (Month) _____ (Day) _____ (Year) _____		
AGE <u>About 22</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Wife of hon. 23</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Ills.</u>		

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 11, 1910
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from March 1910, to June 11, 1910, that I last saw her alive on June 3, 1910, and that death occurred, on the date stated above, at 3-a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Heart failure
after slight fatigue & worry
(Duration) 4 yrs. _____ mos. _____ ds.

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

(Signed) C. W. Holt M.D. M. D.
6-11-10 (Address) Chamonia 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 6 yrs. _____ mos. _____ ds. In the 6 yrs. _____ mos. _____ ds. State _____
Where was disease contracted if not at place of death? Hayward Co. Mo.
Former or usual residence. Ills.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE •

(Informant) John H. Turner
(ADDRESS) Chamonia Mo.

Filed June 14, 1910 J. R. McShee REGISTRAR

PLACE OF BURIAL OR REMOVAL Hooland Cemetery DATE OF BURIAL 6-13-10
UNDERTAKER Citizen ADDRESS Chamonia Mo.
Marion

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 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, peritonaeum*, 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.)



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

PLACE OF DEATH

County Madison

Township Back River

Village _____

City _____

Registration District No. 892

Primary Registration District No. 6194

File No. _____

Registered No. _____

(NO. _____)

St. _____

Ward _____

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

FULL NAME Goldie Monda Turner

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Yes

DATE OF BIRTH

Unknown

AGE

about 22 yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

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

Widow at Home

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

BIRTHPLACE

(City or town, State or foreign country)

Ills

PARENTS

NAME OF FATHER

Allen White

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

Ind.

MAIDEN NAME OF MOTHER

Mary Deal

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

Ills

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Jessie A. Turner
Channah Mo

Filed

June 15, 1910

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

June 11, 1910

I HEREBY CERTIFY, that I attended deceased from mech, 1910, to June 11, 1910, that I last saw her alive on June 3, 1910, and that death occurred, on the date stated above, at 2:4 am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Heart Failure
after slight fatigue & worry

Contributory

(SECONDARY)

(Signed)

C. W. Holtz M. D.
6-11, 1910 (Address) Channah 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 4 yrs. _____ mos. _____ ds. In the 6 yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? Maywood, Mo

Former or usual residence Ills

PLACE OF BURIAL OR REMOVAL

Woodland

DATE OF BURIAL

_____ 1910

UNDERTAKER

ADDRESS

Revised United States Standard Certificate of Death

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

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191007 Supplemental

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," "Infantion," "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.)

