

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty Clay

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City Liberty Mo. (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)Registration District No. 207File No. 769Primary Registration District No. 3012Registered No. 7

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

FULL NAME Mrs Sara A Simmons

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widow  
(Write the word)DATE OF BIRTH Oct 12, 1869  
(Month) (Day) (Year)AGE 44 yrs. 3 mos. 3 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) 9-0

## BIRTHPLACE

(City or town, State or foreign country) Flate City MoNAME OF FATHER James BradyBIRTHPLACE OF FATHER Ky  
(City or town, State or foreign country)MAIDEN NAME OF MOTHER Euna AlderBIRTHPLACE OF MOTHER England  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. C. Adams(ADDRESS) Liberty MoFiled 1/18/11 1911 Wm. G. Goodson REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 11, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan 4, 1911, to Jan 11, 1911, that I last saw her alive on Jan 11, 1911, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH\* was as follows:

La Grippe11 1/2 (Duration) yrs. 16 mos. 16 ds.Contributory Dr.  
(SECONDARY)11 1/2 (Duration) yrs. 16 mos. 16 ds.(Signed) W. C. Adams M. D.Jan 12, 1911 (Address) Liberty 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

Liberty

DATE OF BURIAL

Jan 18, 1911

UNDERTAKER

Dev. Steel

ADDRESS

Liberty

# 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, Composer, 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.)



Statement of OCCUPATION is very important.

PLACE OF DEATH

County Clay  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City Liberty (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH  
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 201 File No. 769  
Primary Registration District No. 3012 Registered No. 7

FULL NAME (Mrs) Sara A. Simmons

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

PERSONAL AND STATISTICAL PARTICULARS

SEX W COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Widow

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE 42 yrs 3 mos \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

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

PARENTS NAME OF FATHER James Broad  
BIRTHPLACE OF FATHER \_\_\_\_\_  
MAIDEN NAME OF MOTHER Emma Miller  
BIRTHPLACE OF MOTHER \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs W. C. Adams  
(ADDRESS) Liberty Mo.

Filed 3/6/11 by Wm. H. Gordon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_, 1911  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from Jan-4, 1911, to 1-11, 1911, that I last saw her alive on 1-11, 1911, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:  
a grippe -  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 16 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. H. Matthews M. D.  
1-12, 1911 (Address) Liberty, 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 Liberty DATE OF BURIAL 1-13, 1911  
UNDERTAKER H. W. Hill ADDRESS Liberty

# Revised United States Standard Certificate of Death

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Association]

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