

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

County Pen R  
Township Union  
or  
Village  
or  
City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 701

File No. 2945

Primary Registration District No. 5930

Registered No. 5

FULL NAME Flores Opal Trees

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Sept 20<sup>th</sup> 1910 (Month) (Day) (Year)  
AGE \_\_\_\_\_ yrs. 4 mos. 6 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) 0

BIRTHPLACE (City or town, State or foreign country) Union Town Pa. Pa.

PARENTS NAME OF FATHER A. Allison Trees, Jr. BIRTHPLACE OF FATHER (City or town, State or foreign country) Bellevue Mo. MAIDEN NAME OF MOTHER Francis L. Allison BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bellevue Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed Jan 27 1911

W. S. Hopkins  
By Joel W. Crandall, Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 27 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 26<sup>th</sup>, 1911, to Jan 27<sup>th</sup>, 1911, that I last saw her alive on Jan 26<sup>th</sup>, 1911, and that death occurred, on the date stated above, at 5 A.M. The CAUSE OF DEATH\* was as follows:

Cerebral Pneumonia  
107A

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D. Jan 27<sup>th</sup> 1911 (Address) St. Louis 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

Greenwood Cemetery

UNDERTAKER \_\_\_\_\_

DATE OF BURIAL

Jan 27 1911

ADDRESS \_\_\_\_\_

# 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.)



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important.

PLACE OF DEATH \_\_\_\_\_

MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 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 Polk  
 Township Marion  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 701 File No. 2945  
 Primary Registration District No. 5930 Registered No. \_\_\_\_\_

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

FULL NAME Flossie Opal Wells

PERSONAL AND STATISTICAL PARTICULARS

|  |                           |   |
|--|---------------------------|---|
| SEX<br><u>F</u>  | COLOR OR RACE<br><u>W</u> | SINGLE MARRIED WIDOWED OR DIVORCED<br>(Write the word)<br><u>Single</u> |
| DATE OF BIRTH<br><u>9-20</u> , 19 <u>10</u><br>(Month) (Day) (Year)  |                           |   |
| AGE<br><u>4</u> yrs. <u>6</u> mos. <u>6</u> ds.  |                           | If LESS than 1 day, _____ hrs. or _____ min.?                           |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>none</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) |                           |   |

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from 1-20, 1911, to 1-27, 1911, that I last saw her alive on 1-26, 1911, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH\* was as follows:  
Catarhal Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

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

|         |  |  |
|---------|--|--|
| PARENTS | NAME OF FATHER<br><u>R. Allison Wells</u>  | (Duration) _____ yrs. _____ mos. _____ ds.               |
|         | BIRTHPLACE OF FATHER (City or town, State or foreign country)<br><u>Ballevue Mo.</u> | (Signed) <u>J. T. Roberts</u> M. D.                      |
|         | MAIDEN NAME OF MOTHER<br><u>Francis K. Stevens</u>                                   | <u>1-27</u> , 19 <u>11</u> (Address) <u>Ballevue Mo.</u> |
|         | BIRTHPLACE OF MOTHER (City or town, State or foreign country)<br><u>Ballevue Mo.</u> |  |

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

\*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 (Informant) R. Wells X

(ADDRESS) Ballevue Mo. X  
 Filed Jan 27, 1911 W. S. Hopkins REGISTRAR X

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<br><u>Ballevue Mo.</u> | DATE OF BURIAL<br><u>1-27</u> , 19 <u>11</u> |
| UNDERTAKER<br><u>none</u>                         | ADDRESS<br><u>X</u>                          |

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

27

DEC

# Revised United States Standard Certificate of Death

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

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