

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

PLACE OF DEATH
County New Madrid
Township 11
or
Village _____
or
City _____

Registration District No. 604 File No. 15134
Primary Registration District No. 6802 Registered No. _____

FULL NAME Mattie Northern (No. _____ St. _____ Ward _____)

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH April 7th, 1911
(Month) (Day) (Year)

DATE OF BIRTH 27, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 10, 1911, to April 7, 1911, that I last saw her alive on March 7, 1911, and that death occurred, on the date stated above; at 6a m. The CAUSE OF DEATH* was as follows:

AGE 6 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 130 Tuberculosis
(Duration) _____ yrs. _____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory Scorbutic
(Duration) _____ yrs. _____ mos. 14 ds.

BIRTHPLACE (City or town, State or foreign country) Freedom Ky

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

Signed B McKenny M. D. April 7, 1911 (Address) New Madrid Mo

*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)

(Informant) J. N. Nelson

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.:

(ADDRESS) Kewanee Mo

Where was disease contracted if not at place of death? _____

Filed 4-7 1911 Ms. C. Richards REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Kewanee DATE OF BURIAL 4-8, 1911

UNDERTAKER B Richards ADDRESS New Madrid Mo

N. B.—Every item of information 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.

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, 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.)



PLACE OF DEATH

County New Madrid
 Township New Madrid
 or
 Village _____
 or
 City _____

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. 604 File No. 15134
 Primary Registration District No. 5802 Registered No. _____
 (NO. _____ St. _____ Ward _____)

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

FULL NAME Mattie Northern

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Singles</u>
DATE OF BIRTH <u>X</u> <u>1</u> - <u>1705</u> (Month) (Day) (Year)		AGE <u>6</u> yrs. _____ mos. _____ ds. 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) _____		
BIRTHPLACE (City or town, State or foreign country) <u>X Ky</u>		
PARENTS	NAME OF FATHER <u>X</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>X</u>	
	MAIDEN NAME OF MOTHER <u>X</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>X</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 7th, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 10, 1911, to Apr. 7, 1911, that I last saw her alive on Mar. 7, 1911, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH was as follows:
Nephritis

(Duration) 8 weeks ds.
 Contributory Scorlitina
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. B. McKinney, M. D.
Apr. 7, 1911 (Address) New Madrid, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. N. Jackson
 (ADDRESS) Kwanu, Mo.
 Filed X-7 1911 Ms. C. B. Richards
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Kewanee DATE OF BURIAL 4-8, 1911
 UNDERTAKER C. B. Richards ADDRESS New Madrid

Revised United States Standard Certificate of Death

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

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