

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 Marion V
 Township B. Jefferson Registration District No. 01401 File No. 35213
 or
 Village _____ Primary Registration District No. 0737 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 Mary Stiles

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH March 9th, 1846
(Month) (Day) (Year)

AGE 65 yrs. 5 mos. 14 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) Gasconade Co.

BIRTHPLACE
 (City or town, State or foreign country) Gasconade Co.

PARENTS
 NAME OF FATHER Robert Leach
 BIRTHPLACE OF FATHER Bellville, Ill
 MAIDEN NAME OF MOTHER Elizabeth Leach
 BIRTHPLACE OF MOTHER Bellville, Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Abraham Leach
 (ADDRESS) Belleville

Filed Oct 17 1911 J. B. Underwood REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 23, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 23, 1909, to Aug 23, 1911, that I last saw her alive on June 29, 1911, and that death occurred, on the date stated above, at 16, m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Bronchial Asthma)
9711
56 E (Duration) 2 yrs. ___ mos. ___ ds.
117
 Contributory Rheumatism
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) M. O. Spurgeon M. D.
Aug 23 1911 (Address) Red Bird 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 High Gate Mo DATE OF BURIAL Aug 24, 1911
 UNDERTAKER Geo Brewitt ADDRESS High Gate

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.)



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

County Marion
 Township S. Jefferson
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward)

Registration District No. 5-45 File No. _____
 Primary Registration District No. 5-737 Registered No. 3

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

FULL NAME

Mary Stites

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
 DATE OF BIRTH March 9, 1846
(Month) (Day) (Year)
 AGE 65-5-14
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

DATE OF DEATH Aug 23, 1911
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from Nov 23, 1909, to Aug 23, 1911, that I last saw her alive on June 29, 1911, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Bronchial Asthma)

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

(Duration) 2 yrs. mos. ds.

PARENTS
 NAME OF FATHER Robert Leach
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Belleville Ill.
 MAIDEN NAME OF MOTHER Elizabeth Leach
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Belleville Ill.

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

(Signed) M. E. Purgason M. D.
Aug 23, 1911 (Address) Red Bird 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
 (Informant) Aubrey Leach
 (ADDRESS) Owensville

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 _____

Filed Sept 1, 1911 REGISTRAR J. H. ...

PLACE OF BURIAL OR REMOVAL High Gate Mo DATE OF BURIAL Aug 24, 1911

UNDERTAKER Geo Prewitt ADDRESS High Gate Mo.

Revised United States Standard Certificate of Death

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

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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.)