

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 Benton  
 Township Alexander Registration District No. 62 File No. 134  
 or  
 Village \_\_\_\_\_ Primary Registration District No. 5-098 Registered No. 17  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**FULL NAME** Permelia Powell

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

**PERSONAL AND STATISTICAL PARTICULARS**

<b>SEX</b> <u>Female</u>	<b>COLOR OR RACE</b> <u>White</u>	<b>SINGLE MARRIED WIDOWED OR DIVORCED</b> <u>Widow</u> (Write the word)
<b>DATE OF BIRTH</b> <u>July 14, 1828</u> (Month) (Day) (Year)		
<b>AGE</b> <u>86 yrs 5 mos 4 ds.</u>		If LESS than 1 day, _____ hrs. or _____ min.?
<b>OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>0</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>0-0</u>		
<b>BIRTHPLACE</b> (City or town, State or foreign country) <u>Virginia</u>		
<b>PARENTS</b>	<b>NAME OF FATHER</b> <u>Wm Robinson</u>	
	<b>BIRTHPLACE OF FATHER</b> (City or town, State or foreign country) <u>Virginia</u>	
	<b>MAIDEN NAME OF MOTHER</b> <u>Didn't know</u>	
	<b>BIRTHPLACE OF MOTHER</b> (City or town, State or foreign country) <u>Didn't know</u>	

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH** Dec 18, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 15, 1911, to Dec 18, 1911, that I last saw him alive on Dec 18, 1911, and that death occurred, on the date stated above, at 10 A.M.

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

97

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

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

(Signed) Marion Shellen M. D.  
Jan 8, 1912 (Address) Quirfield, 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) Mrs. Milt Cauter  
 (ADDRESS) Quirfield, Mo

Filed Jan 8, 1912 Marion Shellen  
 REGISTRAR

<b>PLACE OF BURIAL OR REMOVAL</b> <u>Shiloh Cemetery</u>	<b>DATE OF BURIAL</b> <u>Dec 19, 1911</u>
<b>UNDERTAKER</b> <u>Mahlan White</u>	<b>ADDRESS</b> <u>Mersau</u>

**PLACE OF DEATH**

\* County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

Ward \_\_\_\_\_

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

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____	_____ yrs. _____ mos. _____ 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) \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_  
(City or town, State or foreign country)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(informant) \_\_\_\_\_

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

Filed \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_, 191\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

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

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

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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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.

PLACE OF DEATH

County Benton  
 Township Alexander  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 02  
 Primary Registration District No. 5098

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

File No. 134  
 Registered No. 17

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

FULL NAME Permelia Powell

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 14 1925  
 (Month) (Day) (Year)

AGE 86 yrs. 5 mos. 4 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 18 1911  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 15 1911, to Dec 18 1911, that I last saw alive on Dec 18 1911, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:  
Lobar pneumonia

BIRTHPLACE (City or town, State or foreign country) Virginia

PARENTS  
 NAME OF FATHER Asst. Robert  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Va  
 MAIDEN NAME OF MOTHER Star  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 ds.

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

(Signed) Marion Dillan M. D.  
Jan 3 1912 (Address) Fairfield 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) Mrs Melt Crabtree  
 (ADDRESS) Fairfield Mo.

Filed Jan 3 1912 Marion Dillan  
 REGISTRAR

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 Shiloh Cem DATE OF BURIAL Dec 19 1911  
 UNDERTAKER Mahlow White ADDRESS Narsair

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

# 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," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "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.)