

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.

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

PLACE OF DEATH
County Buchanan
Township Platte
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 80 File No. 185
Primary Registration District No. 5721. Registered No. 5-

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

FULL NAME Mary Jane Nash

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE Widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH Dec 28, 1889
(Month) (Day) (Year)

DATE OF DEATH Jan 18, 1912
(Month) (Day) (Year)

AGE 78 yrs. - 20 mos. 20 ds.
IF LESS than
1 day, _____ hrs.
or _____ min.?

I HEREBY CERTIFY, that I attended deceased from Jan 11, 1912, to Jan 17, 1912,
that I last saw her alive on June 17, 1912,
and that death occurred, on the date stated above, at 4 P.M.

OCCUPATION
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

The CAUSE OF DEATH* was as follows:
Pneumonia from
10: 17

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

(Duration) _____ yrs. _____ mos. _____ ds.

PARENTS
NAME OF FATHER Don't know
BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. D. Reynolds M. D.
Jan 23, 1912 (Address) Gower Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Nash
(ADDRESS) Gower 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 _____

Filed 1/24 1912 A. J. Dowell REGISTRAR

PLACE OF BURIAL OR REMOVAL Hebron cemetery DATE OF BURIAL Jan. 19, 1912
UNDERTAKER Lucian Davis ADDRESS Edenton Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County.....

Township.....
or.....

Village.....
or.....

City.....(NO.....)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

St.:.....Ward).....
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)....., 191....., (Day)....., (Year).....	
AGEyrs.,.....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)
(Signed)....., 191..... (Address)..... M. D.
.....yrs.,.....mos.....ds.
.....yrs.,.....mos.....ds.

* State the Disease Causing Death, or, in deaths from Violent Cause, 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

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 Boychauveau
Township Platte
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RE-
QUIRE 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. 86 File No. 195
Primary Registration District No. 5721 Registered No. 3

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

FULL NAME Mary Jane Nash

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec 28, 1839
(Month) (Day) (Year)

AGE 93 yrs. 20 mos. 20 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS NAME OF FATHER Ornt Koller 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) Geo Nash (ADDRESS) Gower Mo

Filed 1/19 - 1912 R. J. Dorell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 18, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 11, 1912, to Jan 17, 1912, that I last saw him alive on Jan 17, 1912, and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. D. Reynolds M. D. (Address) Gower 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 Abbeville DATE OF BURIAL Jan 19, 1912
UNDERTAKER Lucius Davis ADDRESS Edgerton Mo

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

SUPPLEMENTARY

JAN

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.)