

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.

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

**PLACE OF DEATH**

County Franklin Mo  
Township Union  
or  
Village Cassville Mo  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 282 File No. 750  
Primary Registration District No. 5401 Registered No. 99

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

**FULL NAME** Miss Lilia Thompson

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH _____/_____/_____ (Month) (Day) (Year)		
AGE <u>14</u> yrs. ____ mos. ____ ds.		
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) <u>school girl</u>		
BIRTHPLACE (City or town, State or foreign country) <u>mo. O</u>		
PARENTS	NAME OF FATHER <u>Jim Thompson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill</u>	
	MAIDEN NAME OF MOTHER <u>Miss Lilia John</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Sheets  
(ADDRESS) Cassville Mo

Filed 1/8 1912 r. G. W. Brown  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH  
12 / 28 / 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 18, 1912, to Dec 27, 1912, that I last saw her alive on Dec 25, 1912, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH\* was as follows:

Chloria Blood Poison  
139 E  
36  
(Duration) — yrs. 0 mos. — ds.  
Contributory Female Trouble  
(SECONDARY) (Duration) — yrs. 0 mos. — ds.

(Signed) G. W. Sheets M. D.  
Cassville Mo (Address)

\* Since 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 RESIDENT 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 12/29 1912

UNDERTAKER O. McPord ADDRESS Cassville Mo

# 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*, *Compositor*, *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 septichaemia," "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.)



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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH \_\_\_\_\_  
 County Dunklin  
 Township Mason  
 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. 282 File No. 750  
 Primary Registration District No. 5401 Registered No. 99

FULL NAME Miss Lillie Thompson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S.</u>
DATE OF BIRTH <u>1-4-1898</u> (Month) (Day) (Year)		
AGE <u>14</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>		
PARENTS	NAME OF FATHER <u>Jim Thompson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill</u>	
	MAIDEN NAME OF MOTHER <u>Miss Violet Johnson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>G. N. Schetz</u> (ADDRESS) <u>Campbell Mo</u>		
Filed <u>1/8</u> 191 <u>2</u> <u>G. M. Brown</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 28, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1912, to Dec 27, 1912, that I last saw deceased on Dec 27, 1912 and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:  
Chronic Blood Poison

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

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

(Signed) G. N. Schetz M. D.  
1/7 1912 (Address) Campbell 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 <u>Wicket</u>	DATE OF BURIAL <u>12-29 1912</u>
UNDERTAKER <u>McBride</u>	ADDRESS <u>Campbell Mo</u>

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

JAN

# Revised United States Standard Certificate of Death

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

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