

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 Macou  
Township \_\_\_\_\_  
or Village Ethel  
or City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 5-31  
Primary Registration District No. 6-47  
4317

File No. 1890

Registered No. 29

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

FULL NAME Susan Edwards

**PERSONAL AND STATISTICAL PARTICULARS**

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

DATE OF BIRTH Feb 28, 1856  
(Month) (Day) (Year)

AGE 55 yrs. 10 mos. 21 ds. IF LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Keeper  
(b) General nature of industry, business, or establishment in which employed (or employer) Q-C

BIRTHPLACE (City or town, State or foreign country) Macou Co Mo

PARENTS  
NAME OF FATHER Joseph Bailey  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia  
MAIDEN NAME OF MOTHER Elvira Loberie  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) T. F. Charles  
(ADDRESS) Ethel Mo.

Filed Jan-19, 1912 Francis W. Dren REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Jan 17, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 7, 1912, to Jan 17, 1912, that I last saw her alive on Jan 17, 1912, and that death occurred, on the date stated above, at 9:30 a.m.

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

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

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

(Signed) Francis W. Dren M. D. Jan 18, 1912 (Address) Ethel 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 Ethel Cemetery DATE OF BURIAL Jan-19, 1912

UNDERTAKER H. A. Maroon ADDRESS Ethel Mo.

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 \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_  
 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (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) _____
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) _____	

**MEDICAL CERTIFICATE OF DEATH**

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

**BIRTHPLACE**

(City or town, State or foreign country)

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**NAME OF FATHER**

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

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**MAIDEN NAME OF MOTHER**

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

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) \_\_\_\_\_

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

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_\_

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

REGISTRAR

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

**Contributory**

(SECONDARY)

(Signed) \_\_\_\_\_, 191\_\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_

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

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

\*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. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

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

PLACE OF DEATH  
County Macou REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Township Ethel Registration District No. 531 File No. 1890  
Village Ethel Primary Registration District No. 4317 Registered No. 29  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_  
FULL NAME Susan Edwards (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OF RACE <u>white</u>	SINGLE MARRIED <u>widower</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Feb 28 1856</u> (Month) (Day) (Year)		
AGE <u>53 yrs 10 mos 21 ds.</u>		IF LESS than 1 day, _____ hrs or _____ min
OCCUPATION (a) Trade, profession, or particular kind of work <u>housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Macou, Mo</u>		
PARENTS	NAME OF FATHER <u>Joseph Bailey</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Va</u>	
	MAIDEN NAME OF MOTHER <u>Rebecca Lovell</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Va</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Jan 17 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 7 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 9:30 a.m.

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

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

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

(Signed) Francis W Brown M. D.  
Ethel Mo 1912 (Address)

\*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  
Ethel Cem, Ethel Mo

DATE OF BURIAL  
Jan 19 1912

UNDERTAKER  
R A Macou

ADDRESS  
Ethel Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) P. F. Clardy  
(ADDRESS) Ethel Mo

Filed Jan 19 1912 Francis W Brown REGISTRAR

Original file, date Jan 19 1912 All information called for must be written on this Supplementary Certificate.

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.

RECORDS IN FULLY WITH UPDATING—THIS IS A PERMANENT RECORD

# 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.)