

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PRELIMINARY REPORT.

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 Boone

Township _____ or Village _____ or City Columbia (NO. _____) (St. _____) (Ward _____)

Registration District No. 73 File No. 4194

Primary Registration District No. 3006 Registered No. 37

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

FULL NAME Hellen Ann Robinson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>America</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Dec 21, 1889</u> (Month) (Day) (Year)		
AGE <u>82</u> yrs. <u>2</u> mos. <u>6</u> ds.		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) <u>7-35</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Boone Co Mo.</u>		
PARENTS	NAME OF FATHER <u>Maxwell Robinson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>South Carolina</u>	
	MAIDEN NAME OF MOTHER _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Richmond Va</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2-23, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-23, 1912, to _____, 1912, that I last saw h alive on 2-22, 1912, and that death occurred, on the date stated above, at 7 1/2 mi.

The CAUSE OF DEATH* was as follows:
General Debility
1330
167-1 (Duration) yrs. mos. ds.

Contributory Kidney Trouble
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. W. Don M. D.
(Address) Kansas City

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Robinson
(ADDRESS) Columbia Mo.

Filed Feb 28 1912 W. H. Kampshmidt
REGISTRAR

*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 Columbia DATE OF BURIAL Feb 28, 1912

UNDERTAKER Parley Bus Co ADDRESS Columbia

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 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.)



PLACE OF DEATH

County

Boone

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

Township

Registration District No.

93

File No.

Village

Primary Registration District No.

3006

Registered No.

39

City

Columbia

(NO.

St.

Ward)

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

FULL NAME

Hellen Ann Robinson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

DATE OF BIRTH

Dec 21, 1829

(Month)

(Day)

(Year)

AGE

82 2 6

yrs.

mos.

ds.

if LESS than
1 day, ... hrs.
or ... mins.

DATE OF DEATH

2 - 27, 1912

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from
25 23, 1912, to _____, 1912,

that I last saw her alive on 2 - 22, 1912,

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

General debility

OCCUPATION

(a) Trade, profession, or
particular kind of work

Housekeeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)

Boone Co. Mo.

NAME OF
FATHER

Maximilian Robinson

BIRTHPLACE
OF FATHER
(City or town, State or foreign country)

South Carolina

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

Richmond Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

Edith Robinson

(ADDRESS)

Columbia

Filed

4/11, 1912

1912

REGISTRAR

Contributory
(SECONDARY)

Kidney trouble

(Signed)

O. M. Long

M. D.

Feb 28, 1912 (Address) Columbia 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

Columbia

DATE OF BURIAL

Feb 28, 1912

UNDERTAKER

Gandy Fur Co.

ADDRESS

Columbia

Original file, date

FEB 28, 1912

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

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[Approved by U. S. Census and American Public Health
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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.)

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