

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 Greene
 Township N. Campbell Registration District No. 318 File No. 9008
 or
 Village Nichols Mo. Primary Registration District No. 5439 Registered No. 16
 or
 City Nichols Mo. (NO. Nichols Mo. St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Bessie Richardson

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Child</u> (Write the word)
DATE OF BIRTH <u>Feb. 1, 1912</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>4</u> mos. <u>4</u> ds. If LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Greene Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>J. M. Richardson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Wabster Co Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Sarah Haynie</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kansas</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. M. Haynie</u> (ADDRESS) <u>Nichols Mo</u>		
Filed <u>Mar. 6, 1912</u> <u>J. B. Limmon</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 5, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1912, to March 4, 1912, that I last saw him alive on March 4, 1912, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
92 P
82 P
 (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) W. E. Albright M. D.
March 6, 1912 (Address) Springfield 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>Clear Creek Mo</u>	DATE OF BURIAL <u>March 6, 1912</u>
UNDERTAKER <u>W. E. Johnson</u>	ADDRESS <u>305 W. Walnut</u>

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 GreeneTownship N. Campbell

Village _____

City _____

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

Registration District No. 318Primary Registration District No. 5-439(NO. Nichols Mo. St.; _____ Ward)

File No. _____

Registered No. 16

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

FULL NAME

Bessie Richardson

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)DATE OF BIRTH Feb 1, 1912
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

(a) Trade, profession, or particular kind of work none

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

BIRTHPLACE

(City or town, State or foreign country) Greene Co Mo.NAME OF FATHER J.M. RichardsonBIRTHPLACE OF FATHER (City or town, State or foreign country) Nichols Co Mo.MAIDEN NAME OF MOTHER Sarah HaynieBIRTHPLACE OF MOTHER (City or town, State or foreign country) Kansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Haynie
(ADDRESS) Nichols Mo.Filed May 13, 1912 G. B. Emmons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 5, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mar 1, 1912, to Mar 4, 1912, that I last saw him alive on Mar 4, 1912, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

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

Contributory

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

(Signed) W. E. Albright M. D.
3/6, 1912 (Address) Springfield 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 Clear Creek Mo DATE OF BURIAL Mar 6, 1912UNDERTAKER W. C. Lohmeyer ADDRESS 305 N. WalnutOriginal file, date MAR, 19____ All information called for must be written on this Supplementary Certificate.

WRITE PLAINLY, WITH

N. B. - CAUSE OF DEATH in plain language, actually property of the State of Missouri, and is not to be written in any other language.

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) *Colton 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, Sarcoma*, 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.)

8008

MARGIN RESERVED FOR BINDING

WITH UNFADING INK—IT

PHYSICIANS should state EXACTLY BY WHOM the death was certified. Exact spelling of name is very important.

PLACE OF DEATH

County Greene
Township _____
or
Village Nichols
or
City _____ (NO. _____ St.: _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 318 File No. 9008
Primary Registration District No. 5439 Registered No. 16

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

FULL NAME Bessie Richardson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 2 - 1 - 1912
(Month) (Day) (Year)

AGE 1 yrs. 4 mos. 4 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

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

NAME OF FATHER J. M. Richardson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Webster Co. Mo

MAIDEN NAME OF MOTHER S. Leah Hayme

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

((Informant) J. M. Hayme

(ADDRESS) Nichols, Mo

Filed 3/6 1912 W. L. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/5, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3/1, 1912, to 3/4, 1912, that I last saw her alive on 3/4, 1912, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH was as follows:
Cerebral hemorrhage
19

Contributory Valvular Disease of Heart
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. E. Albright M. D.
3/6, 1912 (Address) Springfield

*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 Clear Creek, Mo DATE OF BURIAL 3/6, 1912

UNDERTAKER Lohmeyer ADDRESS Springfield

Revised United States Standard Certificate of Death

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

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