

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 Standard
 Township Liberty
 or
 Village
 or
 City Berlin (NO. _____ St. _____ Ward _____)

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

Registration District No. 831 File No. 12079
 Primary Registration District No. 6098a Registered No. 20

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

FULL NAME Mollie L. Fullbright

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
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DATE OF BIRTH

6 (Month) 20 (Day) 1878 (Year)

AGE

33 yrs. 9 mos. 1 ds. if LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

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

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

BIRTHPLACE

(City or town, State or foreign country) Albany, N.Y.

PARENTS

NAME OF FATHER

J. J. Jones

BIRTHPLACE OF FATHER

Do not know

MAIDEN NAME OF MOTHER

Orlena Shipley

BIRTHPLACE OF MOTHER

Do not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rebecca(ADDRESS) Berlin, Mo.Filed 3/25 1912 W. C. Allen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

March 21st 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 17th, 1912, to March 20th, 1912, that I last saw her alive on March 20th, 1912, and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
108

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory

(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed)

R. H. Ridge M.D.
3/20, 1912 (Address) Berlin, 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

Stoneman graveyard March 22, 1912

UNDERTAKER

W. L. Hadley Berlin
Mo.

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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.)

HUGH STEPHENS, JEFFERSON CITY.



PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CONDITION and 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

Stoddard
Liberty

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

Registration District No.

836

File No.

12079

Township

Village

City

Primary Registration District No.

6098A

Registered No.

20

(NO.)

St.

Ward

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

FULL NAME

Mollie L. Fullbright

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

M

DATE OF BIRTH

6 20 1878
(Month) (Day) (Year)

AGE

33 yrs. 9 mos. 1 ds.

If LESS than 1 day, hrs. or mins.

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

Housewife

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

BIRTHPLACE (City or town, State or foreign country)

Albany Mo

PARENTS

NAME OF FATHER

J. J. Jones

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

Mo

MAIDEN NAME OF MOTHER

Adean Shipley

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

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Atkins

(ADDRESS)

Bernie Mo.

File

May 10 1912

W. J. Allen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar 21 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Mar 17, 1912 to Mar 20, 1912
that I last saw her alive on Mar 20, 1912,

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Contributory

(SECONDARY)

(Duration) yrs. mos. 7 ds.

(Signed)

B. J. Miller M. D.

May 10 1912

(Address) Bernie 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

Stinson Cem

DATE OF BURIAL

3/22 1912

UNDERTAKER

M. L. Hadley

ADDRESS

Bernie Mo.

Original file, date MAR 3 1912

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

Revised United States Standard Certificate of Death

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

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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.)