

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Pete Co.

Township Greenbriar #2

Village _____

City _____ (NO. _____)

Registration District No. 644

Primary Registration District No. 6882

File No. 14488

Registered No. 10

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

FULL NAME Mabel Nelson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April 11, 1896
(Month) (Day) (Year)

AGE 16 yrs. 8 mos. 8 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) 0

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

NAME OF FATHER Edward Nelson

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

MAIDEN NAME OF MOTHER Ida Cross

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Miss Steffen Cross

(ADDRESS) Windsor Mo.

Filed 4/30 1912 O. E. C. C. C. C. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 20, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 14, 1912, to Mar 21, 1912, that I last saw hw alive on Mar 21, 1912, and that death occurred, on the date stated above, at 4:00 m. The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonalis

(Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) R. L. Shadburne M. D. (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 Windsor Mo. DATE OF BURIAL April 20, 1912

UNDERTAKER W. E. Newton ADDRESS Windsor 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.

S. No. 2.

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, 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.)



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

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

PLACE OF DEATH
County Pettis
Township Green Ridge
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 664 File No. _____
Primary Registration District No. 5882 Registered No. 16

FULL NAME Mabel Nelson

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S.
(Write the word)

DATE OF BIRTH Apr. 11, 1896
(Month) (Day) (Year)

AGE 16 yrs. 8 mos. 8 ds. If LESS than 1 day, ___ hrs or ___ min.

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

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

PARENTS
NAME OF FATHER Edwin Nelson
BIRTHPLACE OF FATHER Pa
MAIDEN NAME OF MOTHER Sada Crose
BIRTHPLACE OF MOTHER Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Stephen Crose
(ADDRESS) Windsor Mo

Filed 6-10 1912 REGISTRAR W. E. Huston

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 20, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 4, 1912, to Mar 20, 1912, that I last saw h alive on Mar. 20, 1912, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Tuberculosis pulmonalis
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory P. A. Blackmore
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) P. A. Blackmore M. D.
6-10 1912 (Address) Old Clabatch

*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 Windsor Mo DATE OF BURIAL Apr 20, 1912
UNDERTAKER W. E. Huston ADDRESS Windsor 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.

SUPPLEMENTARY

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.)

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