

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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Whester</i>		Registration District No.	<i>900</i>	
Township	<i>Union</i>		File No.	<i>16042</i>	
or Village	<i>Nebraska</i>		Primary Registration District No.	<i>6208</i>	
or City			Registered No.	<i>81</i>	
FULL NAME			(If death occurred in a hospital or institution give its NAME instead of street and number)		
<i>Virgie Roder</i>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>Female</i>	<i>White</i>	<i>Single</i>	<i>March 18</i> , 191 <i>2</i>		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
<i>June 26</i> , 1895			_____ , 191____ , to _____ , 191____		
AGE			that I last saw h_____ alive on _____ , 191____		
<i>17</i> yrs. _____ mos. _____ ds.			and that death occurred, on the date stated above, at _____ m.		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work			<i>Tuberculosis</i>		
<i>None</i>			<i>Had no Physician</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)			Contributory		
			(SECONDARY)		
BIRTHPLACE (City or town, State or foreign country)			8 (Duration) _____ yrs. _____ mos. _____ ds.		
<i>Mo</i>			(Signed) _____ M. D.		
PARENTS	NAME OF FATHER		_____ (Address) _____		
	<i>William Roder</i>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	<i>Tenn</i>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
MAIDEN NAME OF MOTHER		Where was disease contracted if not at place of death?			
<i>Sarah J. Williams</i>		Former or usual residence _____			
BIRTHPLACE OF MOTHER (City or town, State or foreign country)		PLACE OF BURIAL OR REMOVAL			
<i>Tenn.</i>		<i>Roder</i>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			DATE OF BURIAL		
(Informant) <i>Wm Roder</i>			<i>3/19</i> , 191 <i>2</i>		
(ADDRESS) <i>Ringva</i>			UNDERTAKER		
Filed <i>4/9/</i> 191 <i>2</i> <i>D A Williams</i> REGISTRAR			<i>Red Grove</i>		
			ADDRESS		
			<i>None</i>		

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.)



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Webster
Township Union
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 900 File No. 16042
Primary Registration District No. 6208 Registered No. 8

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

FULL NAME Virgie Roden

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH June 26, 1895
(Month) (Day) (Year)

AGE 17 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) mo

DATE OF DEATH Mar. 18, 1912
(Month) (Day) (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:
Tuberculosis of the Lungs

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

PARENTS

NAME OF FATHER Wm. Roden

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

MAIDEN NAME OF MOTHER Sarah J. Williams

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

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

(Signed) Physician (Address) at his residence

*State the Disease Causing Death, or, in deaths from Violent Causes, state: (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Roden

(ADDRESS) Marianna

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 _____

Filed April 9, 1912 at Webster REGISTRAR

PLACE OF BURIAL OR REMOVAL Roden DATE OF BURIAL 7/19, 1912

UNDERTAKER Had none ADDRESS none

Revised United States Standard Certificate of Death

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