

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.

V

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

PLACE OF DEATH \_\_\_\_\_  
County Greene  
Township \_\_\_\_\_ Registration District No. 318 File No. 26041  
or  
Village \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 457  
or  
City Springfield NO. Springfield Hospital Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Emily Reagan

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>Aug 20</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>July 18, 1879</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>8/17</u> , 191 <u>2</u> , to <u>8/19</u> , 191 <u>2</u> , that I last saw her alive on <u>8/19</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>4:30 P.M.</u>	
AGE <u>43</u> yrs. <u>1</u> mos. <u>1</u> ds.			The CAUSE OF DEATH* was as follows: <u>B Shock following an operation for uterine fibroid (Fibroid)</u> (Duration) <u>80</u> yrs. mos. ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeper 54</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>At Home</u>			Contributory (Secondary) (Duration) _____ yrs. mos. ds. (Signed) <u>Ha Rura</u> M. D. <u>1912</u> (Address) <u>Springfield Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
PARENTS	NAME OF FATHER <u>William Cooper</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. mos. ds. In the State _____ yrs. mos. ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>		Where was disease contracted If not, at place of death?	
	MAIDEN NAME OF MOTHER <u>Atwood</u>		Former or usual residence _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Canada</u>		PLACE OF BURIAL OR REMOVAL <u>Chelsea Okla.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			DATE OF BURIAL _____ 191 <u>2</u>	
(Informant) <u>W. C. Reagan</u>			UNDERTAKER <u>Haider &amp; Hohmeyer</u>	
(ADDRESS) <u>Estella Okla.</u>			ADDRESS <u>city</u>	
Filed <u>Aug 20</u> , 191 <u>2</u> <u>W. L. Smith</u> REGISTRAR				

# 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 RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.

PLACE OF DEATH

County Greene

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Springfield

Registration District No. 318

Primary Registration District No. 2001

(No. Springfield Hospital St. \_\_\_\_\_

File No. 26041

Registered No. 457

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

FULL NAME Emily Reagan

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED married  
WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH July 18 1879  
(Month) (Day) (Year)

AGE 43 yrs. 1 mos. 1 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ mins.

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

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

PARENTS NAME OF FATHER William Cooper BIRTHPLACE OF FATHER Va  
MAIDEN NAME OF MOTHER Atwood BIRTHPLACE OF MOTHER Canada

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) C. C. Reagan  
(ADDRESS) Estella Okla.

Filed Aug 20 1912 Wilbur Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 20 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8/17, 1912, to 8/19, 1912, that I last saw her alive on 8/19, 1912, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Shock following an operation for uterine fibroid  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) H. A. Lowe M. D. 8/20 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 Chelsea Okla. DATE OF BURIAL 8-20-1912

UNDERTAKER Stader and Lohmeyer ADDRESS Springfield

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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 *septicæmia*," "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.)