

WRITE PLAINLY, WITH UNFADING INK—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.

PLACE OF DEATH

County Pennicott
 Township Cowden
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
Registration District No. 656File No. 27100Primary Registration District No. 5873

Registered No. _____

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

FULL NAME Etahel Gene ~~Wain~~ Naird

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

8 (Month) 1 (Day) 1911 (Year)

AGE

8 yrs. 03 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Infant(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE

(City or town, State or foreign country) Cowden

PARENTS

NAME OF FATHER

W. Naird

BIRTHPLACE OF FATHER

Mo

MAIDEN NAME OF MOTHER

Gene Naird

BIRTHPLACE OF MOTHER

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. A. Naird(ADDRESS) Cowden MoFiled 8/28 1912 Jane A. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

8 (Month) 24 (Day) 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from 8-1, 1912, to 8-24, 1912, that I last saw her alive on 8-22, 1912, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH^t was as follows:Malarial Fever

23 (Duration) yrs. 2 mos. 9 ds.

Contributory _____

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) T. S. Cooper M. D.
Cowden Mo (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

Cowden

DATE OF BURIAL

25 - 1912

UNDERTAKER

Cooper Supply Co. Cowden Mo

ADDRESS

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, peritonaeum*, 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 Perisicot
 Township Coster
 or
 Village

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

Registration District No. 656 File No. 27100
 Primary Registration District No. 5873 Registered No. _____

(NO. _____) (St. _____ Ward _____)

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

FULL NAME Mabel Irene Norich

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|--|---|
| SEX <u>Female</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| DATE OF BIRTH <u>8-1-1911</u> (Month) (Day) (Year) | | |
| AGE <u>1</u> yrs. <u>23</u> mos. <u>23</u> ds. | | If LESS than 1 day, ___ hrs. ___ min. or ___ min. |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Coster, Mo.</u> | | |
| PARENTS | NAME OF FATHER <u>S. A. Norich</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u> | |
| | MAIDEN NAME OF MOTHER <u>Aggie Balliett</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u> | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-24-1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
8-1-1912, 1912, to 8-24-1912,
 that I last saw her alive on 8-22-1912,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

malarial fever

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

Contributory

(SECONDARY)

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

(Signed) J. S. Cooper M. D.
8/24-1912 (Address) Coster, 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

Coster

DATE OF BURIAL

8/25-1912

UNDERTAKER

Coster Supply

ADDRESS

Coster, Mo.

Filed 8/28/1912 James A. Jones REGISTRAR

Original file, date 8/28, 1912

All information called for must be written on this 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.)