

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.

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

PLACE OF DEATH St. Louis ✓
 County St. Louis
 Township Richmond Registration District No. 839 File No. 28418
 or
 Village _____ Primary Registration District No. 6102 Registered No. 410
 or
 City _____ (NO. _____) St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Annie Eliza Shearon

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED OR WIDOWED OR DIVORCED Married
 (If wife the word)

DATE OF BIRTH May 12 1867
 (Month) (Day) (Year)

AGE 45 yrs. 2 mos. 21 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) Henderson Co. Ky.

PARENTS
 NAME OF FATHER B. F. Overfield
 BIRTHPLACE OF FATHER Ky.
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Mrs. Campbell
 BIRTHPLACE OF MOTHER Ky.
 (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 2 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 31 1912 to Aug 2 1912
 that I last saw her alive on Aug 2 1912
 and that death occurred, on the date stated above, at 11 P. m.
 The CAUSE OF DEATH* was as follows:
Obstruction of bowels
127A
127B (Duration) 2 yrs. 4 mos. 4 ds.

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

(Signed) J. P. Brandon M. D.
9-3 1912 (Address) Garage 2800

*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 St. Louis
 DATE OF BURIAL 8/3 1912

UNDERTAKER None
 ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. J. Shearon
 (ADDRESS) Gray Ridge

Filed 8/9 1912 Wm C Caldwell
 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*, *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.)



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 Stoddard
 Township Richland
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 839 File No. 28418
 Primary Registration District No. 6101 Registered No. 40

FULL NAME Ammie Eliza Shearon

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug. 2, 1912
(Month) (Day) (Year)

DATE OF BIRTH May 12, 1867
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 31, 1912, to Aug. 2, 1912,
 first last saw her alive on Aug. 2, 1912,

AGE 45 yrs 2 mos 21 ds.
If LESS than 1 day, hrs. or mins.

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

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

The CAUSE OF DEATH* was as follows:
obstruction of bowels from Femoral Hernia
(Duration) yrs. mos. ds.

BIRTHPLACE (City or town, State or foreign country) Henderson Co. Ky.

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

PARENTS NAME OF FATHER B. F. Overfield
 BIRTHPLACE OF FATHER Ky.
 MAIDEN NAME OF MOTHER Campbell
 BIRTHPLACE OF MOTHER Ky.

(Signed) J. P. Brandon M. D.
8-3 1912 (Address) Essex, Mo.

*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) L. J. Shearon
 (ADDRESS) Gray Ridge

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 _____ 1912 W. Caldwell
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Hexter Cem. DATE OF BURIAL 8/3 1912
 UNDERTAKER none ADDRESS none

N. B.—Every item of information carefully supplied. AGE should be stated EXACTLY. PHYSISIAN'S statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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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.)