

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.

No 8 ✓

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

PLACE OF DEATH _____
County Douglas
Township McMurry or _____
Village _____ or _____
City _____ (NO. _____) St. _____ Ward _____

Registration District No. 272 File No. 35720
Primary Registration District No. 5389 Registered No. _____

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

FULL NAME Marion Woods.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> <small>(Write the word)</small>	DATE OF DEATH <u>September 25, 1912</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH <u>1838</u> — — — — <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>sep 24</u> , 1912, to <u>sep 24th</u> , 1912, that I last saw him alive on <u>sep 24th</u> , 1912, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>acute insufficiency</u>	
AGE <u>74</u> yrs. ____ mos. ____ ds.			92A <u>Unknown</u> <small>(Duration) yrs. mos. ds.</small>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer.</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>FEEL</u>			Contributory <u>0</u> (Secondary) _____ <small>(Duration) yrs. mos. ds.</small> (Signed) <u>David E Archer</u> M. D. _____ 191____ (Address) <u>Squires Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>unknown.</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>Woods</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>unknown</u>		Where was disease contracted If not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER <u>Root</u>		PLACE OF BURIAL OR REMOVAL <u>Nicks Graveyard</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unknown</u>		DATE OF BURIAL <u>sep 27, 1912</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Marion Woods.</u> (ADDRESS) <u>Rippee Mo.</u>			UNDERTAKER <u>Robert Rippee</u>	
Filed <u>Nov 25</u> 191 <u>2</u> <u>M H Osborn</u> REGISTRAR			ADDRESS <u>Rippee Mo</u>	

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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MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH
 County Douglas
 Township McMurtrey
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 272 File No. _____
 Primary Registration District No. 5383 Registered No. _____

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

FULL NAME Darius Woods

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) m

DATE OF BIRTH 1838 _____, _____, _____
 (Month) (Day) (Year)

AGE 74 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) unk

PARENTS
 NAME OF FATHER Woods
 BIRTHPLACE OF FATHER (City or town, State or foreign country) unk
 MAIDEN NAME OF MOTHER Root
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) unk

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Marion Woods
 (ADDRESS) Rippee Mo.

Filed 2/06 25, 1912 REGISTRAR W.H. Osborn

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 25, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 24, 1912, to Sept 24, 1912, that I last saw him alive on Sept 24, 1912, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency

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

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

(Signed) David E. Archer M. D. Sept 26, 1912 (Address) Rippee 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 Sticks Cem DATE OF BURIAL Sept 27, 1912

UNDERTAKER Robt. Rippee ADDRESS Rippee Mo

Revised United States Standard Certificate of Death

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

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