

PLACE OF DEATH

County

Cass

Township

or

Village

or

City

East Lynne

Registration District No.

152

File No.

544

Primary Registration District No.

5276
4086

Registered No.

1

St. Ward

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

FULL NAME

Flora Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX Female	COLOR OR RACE White	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
DATE OF BIRTH Jan 21, 1913 (Month) (Day) (Year)		
AGE yrs. mos. ds.		IF LESS than 1 day, hrs. or min.?
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) East Lynne		
PARENTS	NAME OF FATHER O. N. Smith	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) Cass Co. Mo	
	MAIDEN NAME OF MOTHER Grace Stone	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) East Lynne Mo	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

Jan 21 1918

F. W. Fortin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 21, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1913, to Jan 21, 1913, that I last saw her alive on Jan 21, 1913, and that death occurred, on the date stated above, at 3:20 a.m. The CAUSE OF DEATH* was as follows:

51
epidemic
157 to 8 mo. at birth
(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

F. W. Fortin M. D.

1918 (Address) East Lynne

*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

1st to Chapel

UNDERTAKER

DATE OF BURIAL

Jan 21, 1913

ADDRESS

WITH THIS 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.

Every item of information should be carefully supplied. AGP USE OF DEATH in plain terms, so that it may be properly class. **VS** should state very important.

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

PLACE OF DEATH

County _____

Township _____ File No. _____

or _____

Village _____ Primary Registration District No. _____

or _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

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

AGE _____ yrs. _____ mos. _____ ds.

IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION _____

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

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

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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:

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

Contributory
(SECONDARY)

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

(Signed) _____ (Address) _____ M. D.

*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 _____ in the _____ State _____ yrs. _____ mos. _____ ds.

of death _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, IN INK - UNFOLDING - THIS IS A PERMANENT FILE

NEVER SIGNATURES OF LITIGANTS BEING RECORDED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH as fully as possible. Exact statement of OCCUPATION is very important.

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

CERTIFICATE OF DEATH

PLACE OF DEATH
County Cass
Township _____
or _____
Village _____
or _____
City East Lynne (NO. _____)

Registration District No. 152 File No. _____
Primary Registration District No. 4086 Registered No. 1
St. _____ Ward _____

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

FULL NAME Flora Smith

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>Single</u>	DATE OF DEATH <u>Jan. 21, 1913</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Jan. 21, 1913</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan. 21, 1913</u> , to <u>Jan. 21, 1913</u> , that I last saw her alive on <u>Jan. 21, 1913</u> , and that death occurred, on the date stated above, at <u>3.20 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Inanition</u> <u>7 to 8 mo. at birth</u> (Duration) _____ yrs. _____ mos. _____ ds.	
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?				
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>F. W. Foster</u> M. D. <u>Jan. 21, 1913</u> (Address) <u>East Lynne</u>	
BIRTHPLACE (City or town, State or foreign country) <u>East Lynne</u>				
PARENTS NAME OF FATHER <u>O. W. Smith</u> BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Cass Co.</u> MAIDEN NAME OF MOTHER <u>Lois Stone</u> BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>East Lynne</u>				
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>O. W. Smith</u> (ADDRESS) <u>East Lynne</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
FILED <u>Jan 21 1913</u> <u>F. W. Foster</u> REGISTRAR			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 <u>Pitts Chapel</u> DATE OF BURIAL <u>Jan. 21, 1913</u> ADDRESS _____	
			UNDERTAKER <u>none</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*, *Compositor*, *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*, *Sarcoma*, 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.)

504