

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

County Jasper
Township Helena
or
Village _____
or
City Joplin (NO. 2618 Byres St.; _____ Ward)

Registration District No. 411
Primary Registration District No. 2002

File No. 5673
Registered No. 70

FULL NAME Pauline Phillips

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

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Feb 6 1913
(Month) (Day) (Year)
AGE 11 yrs. 11 mos. 11 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) 0-0

BIRTHPLACE Joplin Mo
(City or town, State or foreign country)

PARENTS
NAME OF FATHER W. B. Phillips
BIRTHPLACE OF FATHER Maxville Iowa
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Hattie Clark
BIRTHPLACE OF MOTHER Albion Iowa
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Phillips
(ADDRESS) Joplin Mo.

Filed Feb 18 1913 A. M. Gegg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ 191____, to Feb 18 1913, that I last saw her living Feb 18 1913, and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

7
measles
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory inadequate lung
(Secondary) amputation (Occupation) _____ yrs. _____ mos. _____ ds.
(Signed) A. P. Snyder M. D.
Feb 18 1913 (Address) Coronet

*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 France DATE OF BURIAL _____ 19L

UNDERTAKER W. H. Hulbert ADDRESS Joplin Mo

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City.....

Registration District No.....

File No.....

Primary Registration District No.....

Registered No.....

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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH.....(Month).....(Day).....(Year).....191.....

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:

Contributory
 (SECONDARY)
 (Signed).....191.....(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 of death.....yrs.....mos.....ds. State.....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, 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.

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 Jarper
 Township _____
 or
 Village _____
 or
 City Joplin

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

CERTIFICATE OF DEATH

Registration District No. 411 File No. _____
 Primary Registration District No. 2002 Registered No. 70
 (NO. 2618 Byers St.: _____ Ward) _____

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

FULL NAME

Pauline Phillips

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

| | | |
|---|---------------------------|--|
| SEX <u>F</u> | COLOR OR RACE <u>W</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> <small>(Write the word)</small> |
| DATE OF BIRTH <u>Feb 6</u> 191 <u>3</u> <small>(Month) (Day) (Year)</small> | | |
| AGE <u>11</u> yrs. <u>11</u> mos. <u>11</u> 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) _____ | | |

DATE OF DEATH July 17 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1913, to Feb 18, 1913, that I last saw him alive on Feb 18, 1913, and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:
emphysema

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

PARENTS

| |
|---|
| NAME OF FATHER <u>W. B. Phillips</u> |
| BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Iowa</u> |
| MAIDEN NAME OF MOTHER <u>Hester Clark</u> |
| BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u> |

(Duration) yrs. ___ mos. ___ ds.

Contributory Probable lung
(Secondary) complication

(Duration) yrs. ___ mos. ___ ds.

(Signed) A. R. Snyder M. D.
2-18 1913 (Address) Corner

*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) W. B. Phillips
 (ADDRESS) Joplin Mo

Filed 2-18 1913 A. M. Yeagy
 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>Jarvis</u> | DATE OF BURIAL <u>2-19</u> 191 <u>3</u> |
| UNDERTAKER <u>Phillips</u> | ADDRESS <u>Joplin 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*, *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.)

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