

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 Gasper
 Township Madison
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 408 File No. 9492
 Primary Registration District No. 5364 Registered No. 35-

 FULL NAME Mrs Mary E Christman

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED <input checked="" type="checkbox"/> OR DIVORCED (Write the word)
DATE OF BIRTH <u>March 12</u> <u>1899</u> (Month) (Day) (Year)		
AGE <u>33</u> yrs. <u>2</u> mos. <u>14</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		

OCCUPATION
 (a) Trade, profession, or particular kind of work House Keeping
 (b) General nature of industry, business, or establishment in which employed (or employer) 9 - 0

BIRTHPLACE
 (City or town, State or foreign country) Indiana
Fire Town

PARENTS	NAME OF FATHER <u>Lewis Stutzman</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>
	MAIDEN NAME OF MOTHER <u>Laura E. Waller</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Indiana</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Richeart
 (ADDRESS) Wentzville Mo

Filed Mar 14 1913 James B. Loyd
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
13 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1913, to March 12, 1913, that I last saw her alive on March 12, 1913, and that death occurred, on the date stated above, at 8:30^{PM} m.
 The CAUSE OF DEATH* was as follows:

Paralysis
820

(Duration) Several months yrs. mos. ds.

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

(Signed) A. X. Corbourn M. D.
3/12 1913 (Address) Wentzville 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 <u>Farkins Cemetery</u>	DATE OF BURIAL <u>3/10</u> 191 <u>3</u>
UNDERTAKER <u>W. Richard</u>	ADDRESS <u>Wentzville 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.)



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PLACE OF DEATH <i>Jasper</i>		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	Registration District No.	File No.	<i>9492</i>
Township	Primary Registration District No.	Registered No.	
or Village			
or City	(NO. _____ St. _____ Ward _____)		(If death occurred in a hospital or institution, give its NAME instead of street and number)
FULL NAME: <i>Mrs Mary E. Chrisman</i>			

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <i>Mar 13</i> , 19 <i>13</i> (Month) (Day) (Year)	
DATE OF BIRTH _____, _____, <i>1</i> _____ (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.	
AGE	If LESS than 1 day, ____ hrs. or ____ min.?		The CAUSE OF DEATH* was as follows: <i>General paralysis of the brain</i> <i>9 3</i> (Duration) <i>Several Years</i> yrs. ds.	
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) <i>J. X. Cordonnier</i> M. D. <i>June 7</i> , 191 <i>3</i> (Address) <i>Avila, Mo</i>	
BIRTHPLACE (City or town, State or foreign country)			*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		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER		Where was disease contracted If not at place of death? Former or usual residence _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)		PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			UNDERTAKER _____ ADDRESS _____	
Filed _____ 191____			REGISTRAR _____	

Revised United States Standard Certificate of Death

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