

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 City
County Worth
Township Worth
or
Village
or
City Sedalia, Mo (NO. RFD #8)
Registration District No. 668 File No. 10249
Primary Registration District No. 3032 Registered No. 73
Ward (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Elizabeth Bohon

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE Widow
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Apr 23, 1819
(Month) (Day) (Year)

AGE 93 yrs. 11 mos. 6 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Joseph Atkins
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER Wm. Godkin 8
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 29, 1919
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 27th March, 1919, to 3-29, 1919, that I last saw her alive on 27th March, 1919, and that death occurred, on the date stated above, at ___ m. The CAUSE OF DEATH* was as follows:
General Debility & Dropsy
957
167 (Duration) ___ yrs. 9 mos. 10 ds.
Contributory General Debility (SECONDARY) (Duration) ___ yrs. 4 mos. 10 ds.
(Signed) S. M. Crawford M. D.
3-31, 1919 (Address) 5105 Ohio av

*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 Fld An Church DATE OF BURIAL 3-31, 1919
UNDERTAKER Sedalia ADDRESS Sedalia Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Bohon
(ADDRESS) RFD #8 Sedalia

Filed March 31, 1919, Sam G. Kelly
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*, *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, peritoneum*, 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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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Pettis REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
Township Sedalia Registration District No. 668 File No. _____
or Village _____ Primary Registration District No. 2033 Registered No. 74
or City Sedalia, Mo. (NO. R.F.D. # 7) St. _____ Ward _____
FULL NAME Elizabeth Bohon [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Widow. (Write the word)
DATE OF BIRTH April 23, 1899 (Month) (Day) (Year)
AGE 93 yrs. 11 mos. 6 ds. If LESS than 1 day, ___ hrs. or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE (City or town, State or foreign country) Kentucky
PARENTS
NAME OF FATHER Joseph Atkins
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER Sarah Godknight
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 29, 1913 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from March 27, 1913, to March 29, 1913, that I last saw her alive on 27 March, 1913, and that death occurred, on the date stated above, at 6 A.M.
THE CAUSE OF DEATH* was as follows:
General Debility & Dropsy -
Due to heart trouble
she was very frail.
(Duration) — yrs. 6 mos. 10 ds.
Contributory General Debility
(Secondary) (Duration) yrs. ___ mos. ___ ds.
(Signed) J. G. Crawford M. D.
3-31, 1913. (Address) 510 S. Ohio Ave.
*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 REGENT 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. Ann Church DATE OF BURIAL 3-31, 1913
UNDERTAKER Sedalia Umb. Co. ADDRESS Sedalia, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Bohon
(ADDRESS) R.F.D. # 7 Sedalia
Filed Mar 31, 1913. Samm G. Kelley REGISTRAR

Revised United States Standard Certificate of Death

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

64201

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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 septicæmia," "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.)