

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 New Madrid
Township Le Dieu
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 606 File No. 20369
Primary Registration District No. 5805 Registered No. 10

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

FULL NAME Adelia M. Geary

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>Wp</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>m</u>
DATE OF BIRTH <u>8. K.</u> <u>1891</u> (Month) (Day) (Year)		
AGE <u>About 32 yrs.</u> If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	NAME OF FATHER <u>Joe Howard</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Mathe Howard</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5-11-1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1913, to 11, 1913, that I last saw her alive on 11th, 1913, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:
Clot in coronary artery of heart.
100% (Duration) ___ yrs. ___ mos. ___ ds.
Contributory Pneumonia (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. W. Rhodes M. D.
5-17-1913 (Address) Px Pleasant

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe M. Geary
(ADDRESS) Px Pleasant Mo.
Filed 6-30, 1913 J. W. Rhodes
REGISTRAR

PLACE OF BURIAL OR REMOVAL Mansby Court, DATE OF BURIAL 5-12-1913
UNDERTAKER Grs. Randolph ADDRESS Px Pleasant Mo.

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.)

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 BIRTH

County New Madrid
Township Lesieur

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

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

Registration District No. 606 File No. _____
Village _____ Primary Registration District No. 5805 Registered No. 10
City _____ (NO. _____ St. _____ Ward _____)
FULL NAME Adelia McGeary [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Satisfactory Information Supplied. COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
AGE _____ yrs. _____ mos. _____ ds. If LESS than _____ day, _____ hrs. _____ of _____ min.
OCCUPATION (a) Trade, profession, 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) _____
PARENTS: NAME OF FATHER _____ BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ MAIDEN NAME OF MOTHER Mattie Mitchell BIRTHPLACE OF MOTHER Tenn.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 11, 1913 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D. _____, 191____ (Address) _____
*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 _____ DATE OF BURIAL _____, 191____
UNDERTAKER _____ ADDRESS _____

JUPPER EMBERTARY Satisfactory Information Supplied.

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Joe Hayward (ADDRESS) Point Pleasant, Mo
Filed June 30, 1913 J. W. Rhodes REGISTRAR

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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