

PLACE OF DEATH

County

Bates

Township

Duncreek

Village

or

City

near Adrian

(NO.

Registration District No.

47

File No.

25441

Primary Registration District No.

5070

Registered No.

2.3

St.

Ward

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

FULL NAME

Minnie May Cause

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Female

COLOR OR RACE

*white*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

DATE OF DEATH

August 1 - 1913

DATE OF BIRTH

June 2, 1877

AGE

*36 yrs. 2 mos. ds.*IF LESS than
1 day, hrs.
or 15 min.?I HEREBY CERTIFY, that I attended deceased from
*Aug 1 - 1913, to Aug 2, 1913,*that I last saw her alive on *Aug 1, 1913,*
and that death occurred, on the date stated above, at *11:40* m.

The CAUSE OF DEATH* was as follows:

*Heart Failure
uræmia
Glycosuria*Contributory
(SECONDARY)*1 yr. 59. 132 lbs. (Duration) 1 yr. 1 mos. 18 ds.
Anurætic Shock*

(Signed)

*J. P. S. M. D.
8/3 - 1913 (Address) Adrian 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

Adrian Mo

DATE OF BURIAL

8/3 - 1913

UNDERTAKER

N. J. Carr

ADDRESS

Adrian Mo

BIRTHPLACE

(City or town,

State or foreign country)

Missouri near Adrian

NAME OF FATHER

Barnett Cause

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ill. near Adrian

MAIDEN NAME OF MOTHER

Mary G. Clark

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ill. waterloo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Barnett Cause

(ADDRESS)

Adrian, Mo.

Filed

8/3 - 1913

REGISTRAR

No. B-1 Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

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*, *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.)



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

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

PLACE OF DEATH Bates
 County Bates Registration District No. 47 File No. _____
 Township Deer Creek or _____ Primary Registration District No. 5070 Registered No. 23
 Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Minnie May Crouse

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. _____ 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) _____

PARENTS

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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 1, 1913
 (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, _____ m.

The CAUSE OF DEATH* was as follows:
Heart Failure
Uremia Dyscemia
and Cong Heart Stroke

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

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

(Signed) A. M. C. M.D.
673 1913 (Address) Adrian 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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Satisfactory Information Supplied.
 (ADDRESS) _____

Filed 73 - 1913 D. W. Smith
 REGISTRAR.

Revised United States Standard Certificate of Death

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

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