

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 Gasconade
Township Bondwars
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 307 File No. 29541
Primary Registration District No. 5425 Registered No. _____

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

FULL NAME Mala Ester Owens

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE white SINGLE Single MARRIED Single WIDOWED Single OR DIVORCED Single
(Write the word)

DATE OF BIRTH April 6, 1913
(Month) (Day) (Year)

AGE 5 yrs. 5 mos. 1 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) Owensville Mo. P.R.D.

PARENTS
NAME OF FATHER Henry Owens
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Beatha Beth
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Owensville Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Owens
(ADDRESS) Owensville Mo

Filed Sep 5, 1913 John S. Eulor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 5, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 5, 1913, to Sept 5, 1913, that I last saw her alive on Sept 5, 1913, and that death occurred, on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
1077 91 V
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) John S. Eulor M. D.
Sept 5, 1913 (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 new Bethel Baptist DATE OF BURIAL Sept 6, 1913
UNDERTAKER Wm P. Hottenrocker ADDRESS Owensville 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

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),

MISSOURI STATE
BUREAU OF VITALS
CERTIFICATE

County _____
 Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registrar _____
 or City _____ (NO. _____) St. _____

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. _____ 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 _____

MEDICAL CERTIFICATE

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

I HEREBY CERTIFY, _____
 _____, 191____, to _____
 that I last saw him _____ alive on _____
 and that death occurred, on the _____
 The CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY) _____
 (Signed) _____ (Duration) _____
 _____ (Address) _____

*State the Disease causing Death, or, if (1) Means of Injury, or (2) Whether Accident
 LENGTH OF RESIDENCE (FOR HOSPITAL RECENT RESIDENTS) _____
 At place of death _____ yrs. _____ mos. _____ ds. _____
 Where was disease contracted if not at place of death _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

UNDERTAKER _____

WRITE PLAINLY, WITH BLUE INK.

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

Township

Village

City

FULL NAME

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

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO.)

St.

Ward

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

AGE

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho Pneumonia

Contributory

(Signed) John S. Peck Sept 5, 1913 (Address) Bay, 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

UNDERTAKER

Original file, date SEP 1913 All information called for must be written on this Supplementary Certificate.

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, 8 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

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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.)