

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 | | MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH | |
|---|--|--|-----------------------------|
| County | <u>Andrew</u> | Registration District No. | <u>28</u> |
| Township | <u>Saling</u> | File No. | <u>38488</u> |
| or | | Primary Registration District No. | <u>5036</u> |
| Village | | Registered No. | <u>20</u> |
| or | | | |
| City | (NO. _____) _____ | St. _____ | Ward _____ |
| FULL NAME <u>Catherine Burkey</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | 3 MEDICAL CERTIFICATE OF DEATH | |
| SEX | COLOR OR RACE | SINGLE | DATE OF DEATH |
| <u>F</u> | <u>W</u> | MARRIED <u>unclassified</u> | <u>Dec 5 1913</u> |
| | | WIDOWED | (Month) (Day) (Year) |
| | | OR DIVORCED | |
| | | (If writ, the word) | |
| DATE OF BIRTH | | I HEREBY CERTIFY, that I attended deceased from | |
| <u>25 - 7 1849</u> | | <u>Nov 21</u> , 191 <u>3</u> , to <u>Dec 5</u> , 191 <u>3</u> , | |
| (Month) (Day) (Year) | | that I last saw her alive on <u>Dec 5</u> , 191 <u>3</u> , | |
| AGE | If LESS than | and that death occurred, on the date stated above, at <u>1:20</u> P.M. | |
| <u>64</u> yrs. <u>6</u> mos. <u>28</u> ds. | 1 day, <u>2</u> hrs. or <u>2</u> min.? | The CAUSE OF DEATH* was as follows: | |
| OCCUPATION | (a) Trade, profession, or particular kind of work | <u>Acute Indigestion</u> | |
| | <u>None</u> | <u>1180</u> | |
| | (b) General nature of industry, business, or establishment in which employed (or employer) | <u>50</u> | |
| | <u>✓</u> | <u>10 15</u> ds. | |
| BIRTHPLACE | (City or town, State or foreign country) | Contributory <u>Impaired Condition of Heart</u> | |
| <u>Boone Co Mo</u> | | (SECONDARY) (Duration) <u>3 1/2</u> yrs. <u>4</u> mos. <u>4</u> ds. | |
| PARENTS | NAME OF FATHER | (Signed) <u>E. L. Scott</u> M. D. | |
| | BIRTHPLACE OF FATHER | <u>125</u> 191 <u>2</u> (Address) <u>Sitting - Mo</u> | |
| | MAIDEN NAME OF MOTHER | * State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | |
| | BIRTHPLACE OF MOTHER | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | |
| <u>Margaret Burkey</u> | <u>Germany</u> | At place of death <u>✓</u> yrs. <u>4</u> mos. <u>4</u> ds. In the State <u>✓</u> yrs. <u>4</u> mos. <u>4</u> ds. | |
| <u>Germany</u> | | Where was disease contracted if not at place of death? <u>✓</u> | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| (Informant) | <u>Lizzie Mae Pallard</u> | | |
| (ADDRESS) | <u>Clark Mo</u> | | |
| Filed | <u>Dec 18</u> , 191 <u>3</u> | <u>E. L. Scott</u> | PLACE OF BURIAL OR REMOVAL |
| | | | <u>Pleasant Grove</u> |
| | | | DATE OF BURIAL |
| | | | <u>12/16</u> , 191 <u>3</u> |
| | | | UNDERTAKER |
| | | | <u>Ernest A Green</u> |
| | | | ADDRESS |
| | | | <u>Clark 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*, *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*, *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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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
 County Cambair
 Township Saling
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 28 File No. _____

Primary Registration District No. 5036 Registered No. 20

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

FULL NAME Catherine Bunker

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, _____, 1913
(Month) (Day) (Year)

AGE _____
If LESS than 1 day, hrs or min. or mos. ds.

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 12/18 1913 E. L. Scott
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Nov 21, 1913, to Dec 5, 1913, that I last saw her alive on Dec 5, 1913,

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Auto-intoxication

Contributory Infarcted condition of heart
(SECONDARY) neff, exhaustion
(Duration) _____ yrs. _____ mos. _____ ds.

Signed E. N. Gentry M. D.
12/5, 1913 (Address) Sturgeon 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 _____ 1913

UNDERTAKER _____ ADDRESS _____

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