

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

PLACE OF DEATH Greene
County Greene
Township Campbell
or Village Springfield
or City no. (NO. 1368 Buttn Ave St. 5 Ward)

Registration District No. 318 File No. 4567
Primary Registration District No. 2001 Registered No. 101

FULL NAME Virginia Althea Dehnig

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

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED Widow WIDOWED OR DIVORCED (If wife the word)

DATE OF BIRTH July 5th, 1830
(Month) (Day) (Year)

AGE 83 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work None 42
(b) General nature of industry, business, or establishment in which employed (or employer) " 95

BIRTHPLACE (City or town, State or foreign country) Frankfort, Ky.

PARENTS
NAME OF FATHER Daniel Bryan
BIRTHPLACE OF FATHER (City or town, State or foreign country) Alexandria, Va.
MAIDEN NAME OF MOTHER Mary Battliff
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Frankfort, Ky.

DATE OF DEATH Feb. 27, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 22, 1914, to Feb. 27, 1914, that I last saw her alive on Feb. 27, 1914, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
A Failure of compensation due to Mitral Insufficiency

(Duration) 2 yrs. 2 mos. 22 ds.
Contributory Senility
(Duration) 1 yrs. 2 mos. 22 ds.

(Signed) Austin C. Ross M. D.
Feb. 27, 1914 (Address) Springfield, 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 2 yrs. 2 mos. 22 ds. In the State 2 yrs. 2 mos. 22 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) P. S. Dehnig
(ADDRESS) Springfield Mo.
Filed 2/28 1914 REGISTRAR

PLACE OF BURIAL OR REMOVAL Maple Park Cem DATE OF BURIAL 2-2- 1914
UNDERTAKER Payson and Co ADDRESS 410 South St

N. B.—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 is very important.

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*, *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 carbonic 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.)

PLACE OF DEATH

County Missouri

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

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Township _____

Registration District No. _____

File No. _____

or Village _____

Primary Registration District No. 2001

Registered No. 101

or City Springfield (NO. 1368 Buttman St. 5 Ward)

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

FULL NAME N. Althea Spring

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h. _____ alive on _____, 191____, and that death occurred, on the date stated above, at 4 P m.

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

The CAUSE OF DEATH* was as follows:

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) _____

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

NAME OF FATHER _____

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

(Signed) _____ M. D. _____, 191____ (Address) _____

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 (City or town, State or foreign country) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death? _____

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLAOF OF BURIAL OR REMOVAL DATE OF BURIAL _____, 191____

Filed 7/28 1914 H. W. Smith REGISTRAR

UNDERTAKER ADDRESS _____

1914

CAUSE OF DEATH IN PLAIN ENGLISH

MISSOURI STATE BOARD OF HEALTH SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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