

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

PLACE OF DEATH

County Pemiscot  
Township Little Prairie  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 051 File No. 5618  
Primary Registration District No. 5849 Registered No. 18

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

FULL NAME Callie Reed

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)  
DATE OF BIRTH Sept 11 1895  
(Month) (Day) (Year)

AGE abt 19 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) X none

BIRTHPLACE (City or town, State or foreign country) Tennessee

NAME OF FATHER Reed

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

MAIDEN NAME OF MOTHER Ellen Johnson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Tidwell

(ADDRESS) Carrithersville, Mo.

Filed 2/12 1914. B. D. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 11 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 9<sup>th</sup>, 1914, to Feb 11<sup>th</sup>, 1914, that I last saw her alive on Feb 11<sup>th</sup>, 1914, and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH\* was as follows:

1573  
Septicemia from an abscess of tooth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. B. Handrix M. D. Feb 12 1914 (Address) Carrithersville, 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. 14 ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence Tennessee

PLACE OF BURIAL OR REMOVAL Moinda DATE OF BURIAL 2/13 1914

UNDERTAKER J. R. Lewis ADDRESS eville

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.

# 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, 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 <sup>or</sup> 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.)

PLACE OF DEATH

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

County

*Peru*

Township

*Little Prairie*

Registration District No.

*651*

File No.

Village

Primary Registration District No.

*5842*

Registered No.

*18*

City

NO.

St.

Ward

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

FULL NAME

*Callie Reed*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

*F*

COLOR OR RACE

*W*

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

*S*

DATE OF DEATH

*2/11*

DATE OF BIRTH

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, (Month) (Day) (Year)

AGE

\_\_\_\_\_, yrs. \_\_\_\_ mos. \_\_\_\_ ds.

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

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 \_\_\_\_\_ m.

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)

NAME OF FATHER

*Reed*

Contributory (SECONDARY)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

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

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

(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

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed *2/12* 191*4*

REGISTRAR

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