

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

7466

PLACE OF DEATH
County Buchanan
Township Crawford Registration District No. 83 File No. _____
Village _____ Primary Registration District No. 5724 Registered No. _____
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Jelma Coyne

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (If write the word)
DATE OF BIRTH <u>September 27, 1910</u> (Month) (Day) (Year)		
AGE <u>3</u> yrs. <u>10</u> mos. <u>19</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>James R. Coyne</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Mabel Shelby</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 15, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1914, to March 15, 1914, that I last saw her alive on March 15, 1914, and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Cerebrospinal meningitis
18 (Duration) yrs. ____ mos. ____ ds.

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

(Signed) M. S. Bull M. D.
3/15/14, 1914 (Address) Faucett 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James R. Coyne
(ADDRESS) Faucett Mo

Filed March 19, 1914 M. S. Bull
REGISTRAR

PLACE OF BURIAL OR REMOVAL Mt. Pleasant DATE OF BURIAL Mar 19, 1914

UNDERTAKER H. A. Sullivan ADDRESS Agency

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, for 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.)

CAUSE OF DEATH in plain terms. It may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Buchanan
Township Crowford
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 83 File No. _____
Primary Registration District No. 5124 Registered No. _____

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

FULL NAME Zelma Coyle

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH March 18, 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 _____ p.m.

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

The CAUSE OF DEATH* was as follows:
Cerebral Meningitis Epidemic

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

(Duration) 61 yrs. 4 mos. 4 ds.

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

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

NAME OF FATHER _____

(Signed) W. S. Skull M. D. 314, 1914 (Address) Laurel mo

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER _____

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

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

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) _____ (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

Filed 3/14, 1914 W. S. Skull REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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