

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

PLACE OF DEATH
County Greene
Township Franklin
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 322 File No. 15887
Primary Registration District No. 5-846 Registered No. 12

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

FULL NAME Lena Callahan

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH June 17, 1894
(Month) (Day) (Year)

DATE OF DEATH Mar 30, 1914
(Month) (Day) (Year)

AGE 99 yrs. 10 mos. ds. IF LESS than 1 day, ____ hrs. or ____ min.?

I HEREBY CERTIFY, that I attended deceased from Mar 28, 1914, to Mar 30, 1914, that I last saw her alive on Mar 29, 1914, and that death occurred, on the date stated above, at 5:22 a.m.

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

The CAUSE OF DEATH* was as follows:
Measles 7
132A

BIRTHPLACE (City or town, State or foreign country) Greene Co Mo

(Duration) ____ yrs. ____ mos. 14 ds.

NAME OF FATHER J. W. Callahan

Contributory (SECONDARY) Hepatitis (with anemia)

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

(Duration) ____ yrs. ____ mos. 6 ds.

MAIDEN NAME OF MOTHER Jane McCurdy

(Signed) Joseph D. James M. D.
3-30, 1914 (Address) Springfield Mo.

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Corone Callahan
(ADDRESS) Springfield

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 _____

Filed May 8, 1914 W. J. Edmondson REGISTRAR

PLACE OF BURIAL OR REMOVAL Belview Cemetery DATE OF BURIAL Mar 29, 1914
UNDERTAKER Paul C. Stader ADDRESS Springfield Mo

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.

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 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*, *telanus*) 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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Greene Registration District No. 322 File No. _____
Township Granville or Village _____ Primary Registration District No. 5446 Registered No. 12
City _____ (NO. _____) (St. _____) (Ward _____)

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

FULL NAME

Lena Callahan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb. 30, 1914
(Month) (Day) (Year)

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

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

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

Measles. 06 *

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

Contributory (SECONDARY) Nephritis (with Noma)

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) _____

(Signed) Joseph J. Jayer M.D. 3/30/14 (Address) Springfield, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

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

(ADDRESS) _____

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 _____

FILED May 8, 1914 M. Edment REGISTRAR

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

UNDERTAKER _____ ADDRESS _____

MAY - 1914

Revised United States Standard Certificate of Death

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

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