

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. CONTINUING LINKS IS A PERMANENT RECORD

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

PLACE OF DEATH
 County Butler
 Township Poplar Bluff or Village _____ or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 89 File No. 28624
 Primary Registration District No. 5131 Registered No. 174

FULL NAME Ida Burkett,

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>	DATE OF DEATH <u>Sept 10</u> , 191 <u>4</u> <small>(Month) (Day) (Year)</small>		
DATE OF BIRTH <u>Don't know</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>Aug 4</u> , 191 <u>4</u> , to <u>Sept 10</u> , 191 <u>4</u> , that I last saw her alive on <u>Sept. 9</u> , 191 <u>4</u> , and that death occurred, on the date stated above, at <u>1 P.</u> m. The CAUSE OF DEATH* was as follows: <u>13 2 3</u> <u>maemic poisoning.</u> <u>Prodrangis trouble</u> <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>		
AGE <u>26</u> yrs. _____ mos. _____ ds.					
OCCUPATION (a) Trade, profession, or particular kind of work <u>County Pauper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory <small>(SECONDARY)</small> _____ <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>		
BIRTHPLACE (City or town, State or foreign country) <u>Butler Co. Mo.</u>			(Signed) <u>J. L. Reisinger</u> M. D. <u>9/10</u> 191 <u>4</u> . (Address) <u>Poplar Bluff</u>		
PARENTS	NAME OF FATHER <u>W. Williams</u>		*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 FATHER (City or town, State or foreign country) <u>Don't know.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	MAIDEN NAME OF MOTHER <u>Don't know.</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know.</u>		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) <u>W. H. Isby</u> (ADDRESS) <u>Poplar Bluff, Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>County farm</u>		
Filed <u>Sept. 10</u> , 191 <u>4</u> . <u>Dr. A. R. Rowe</u> REGISTRAR			DATE OF BURIAL <u>Sept 11</u> , 191 <u>4</u>		
			UNDERTAKER _____ ADDRESS _____		

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, 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Butter
Township Sopler Bluff
Village _____
City _____

Registration District No. 89
Primary Registration District No. 5131

File No. _____
Registered No. 174

FULL NAME

Ida Burkett

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>W</u>
DATE OF BIRTH _____, 191____ (Month) (Day) (Year)		
AGE ____ yrs. ____ 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) _____		

DATE OF DEATH
Sept 10, 1914
(Month) (Day) (Year)

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 _____.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

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

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

(Signed) J. J. Redwine 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. State _____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____
Former or usual residence _____

FILED 1910 SEP 14 1914
REGISTRAR Dr. W. R. R...

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

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied

Satisfactory Information Supplied

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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.)