

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. 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

1 PLACE OF DEATH

County Stoddard
Township Clk
Village _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 228
Primary Registration District No. 6100

File No. 7091-u
Registered No. _____

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

2 FULL NAME

Ann. Jane. Baskin.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widow
(If wife the word)

6 DATE OF BIRTH 4 (Month) 9 (Day) 1897 (Year)

7 AGE 77 yrs. 8 mos. 24 ds. IF LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Gen

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Dowdy
(Address) Union Mo

15 Filed 2-5-1915 Chas. J. Waller Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 (Month) 3 (Day) 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 12-30, 1914 to 1-3, 1915 that I last saw her alive on 1-3, 1915 and that death occurred, on the date stated above, at 11-197, m.

The CAUSE OF DEATH* was as follows:
Paralysis (Ascending)
Age 67

CONTRIBUTORY (Secondary) Age 67
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Dowdy M. D.
1-4, 1915 (Address) Union Mo

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

18 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 _____

19 PLACE OF BURIAL OR REMOVAL Deer tree Cemetery DATE OF BURIAL 1-6, 1915

20 UNDERTAKER C. O. Biggs ADDRESS Deer tree

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 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

Stoddard
Elk

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

County

Township

or Village

or City

Registration District No.

839

File No.

Primary Registration District No.

6100

Registered No.

34

(NO.

St.

Ward)

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

FULL NAME

Ann Jane Caskey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *M* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED *W*
(Write the word)

DATE OF DEATH *1-3*, 191*5*
(Month) (Day) (Year)

DATE OF BIRTH *4-9*, 18*37*
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from *12-30*, 191*4*, to *1-3*, 191*5*, that I last saw him alive on *1-3*, 191*5*, and that death occurred, on the date stated above, at *11:15* p.m.

AGE *77* yrs. *8* mos. *24* ds. If LESS than 1 day, hrs. or mins.

The CAUSE OF DEATH* was as follows:

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

Paralysis ascending

BIRTHPLACE (City or town, State or foreign country) *Greenwood*

(Duration) yrs. mos. ds.

PARENTS NAME OF FATHER *do not know*
BIRTHPLACE OF FATHER (City or town, State or foreign country) *do not know*
MAIDEN NAME OF MOTHER *do not know*
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *do not know*

Contributory (SECONDARY) *Age*
(Duration) yrs. mos. ds.
(Signed) *H. S. Higgins* M. D.
1/4, 191*5* (Address) *Frisen Mo*

*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) *J. L. Dowler*
(ADDRESS) *Frisen Mo*

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 *Jan 1-15* 191*5*
REGISTRAR

PLACE OF BURIAL OR REMOVAL *Dexter Cem* DATE OF BURIAL *1-6*, 191*5*
UNDERTAKER *C. Beys* ADDRESS *Dexter Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

Revised United States Standard Certificate of Death

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

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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.)