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

PLACE OF DEATH

County Henry

Township ~~[illegible]~~ or Village Browningtom or City ______ (NO. ______ St.; ______ Ward)

Registration District No. 348 File No. 68321

Primary Registration District No. 4206 Registered No. 48

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

FULL NAME Nancy Francis Elizabeth Garland

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): ~~[illegible]~~ widowed

DATE OF BIRTH: March 31, 1831 (Month) (Day) (Year)

AGE: 83 yrs. 11 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

(b) General nature of industry, business, or establishment in which employed (or employer): ______

BIRTHPLACE (City or town, State or foreign country): Casey Co Ky.

PARENTS

NAME OF FATHER: Wm Edwards.

BIRTHPLACE OF FATHER (City or town, State or foreign country): Casey Co Ky.

MAIDEN NAME OF MOTHER: Maria Bledsoe.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Casey Co Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J M Parker

(ADDRESS) Roseland mo

Filed Mar. 4 1915. C. D. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 3, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 27, 1915, to March 3, 1915, that I last saw her alive on March 3, 1915, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Influenza.

118

132A (Duration) ___ yrs. ___ mos. 6 ds.

Contributory (SECONDARY) Nephritis.

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. G. Shirley M. D.

Mar. 4, 1915 (Address) Browningtom 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 ______

PLACE OF BURIAL OR REMOVAL: Maplewood cemetery

DATE OF BURIAL: Mar 5 1915

UNDERTAKER: C A Rickett

ADDRESS: Browningtom Mo

N. B.—[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible]

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 *septichaemia*," "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.)

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Henry

Township ______ or Village ______ or City ______ (NO. ______ St.; ______ Ward)

Registration District No. 348 File No. ______

Primary Registration District No. 4206 Registered No. 48

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

FULL NAME Nancy Francois Elizabeth Garland

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX F; COLOR OR RACE W; SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) W	DATE OF DEATH Mch (Month) 3 (Day), 1915 (Year)
DATE OF BIRTH ______ (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 8 P m.
AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ___ hrs. or ___ min.	The CAUSE OF DEATH* was as follows: Influenza complicated with Nephritis. (Duration) 10 yrs. ______ mos. 6 ds.
OCCUPATION (a) Trade, profession, or particular kind of work ______ (b) General nature of industry, business, or establishment in which employed (or employer) none	Contributory (SECONDARY) Nephritis (Duration) ______ yrs. ______ mos. ______ ds.
BIRTHPLACE (City or town, State or foreign country) Casey Co. Ky.	(Signed) U. G. Strieby ? M. D.
PARENTS — NAME OF FATHER Wm Edwards	3/4 1915 (Address) Brownington Mo
BIRTHPLACE OF FATHER (City or town, State or foreign country) Casey Co Ky.	*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 3/4 1915 C. D. Taylor m/o REGISTRAR	UNDERTAKER ______ ADDRESS ______

Original file, date ______ 19__ All information called for must be written on this Supplementary Certificate.

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

Revised United States Standard Certificate of Death

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

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