

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S 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

11393

1 PLACE OF DEATH  
County Washington  
Township Wattson or  
Village or  
City (NO. St. Ward)

Registration District No. 1080 File No.  
Primary Registration District No. 6180 Registered No. 315

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

2 FULL NAME Jessie Allen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH 3 / 3 9/15  
(Month) (Day) (Year)

7 AGE It LESS than 1 day..... hrs. or..... min.?  
..... yrs..... mos. 3 ds.

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

9 BIRTHPLACE (City or town, State or foreign country) Shirley Mo.

PARENTS  
10 NAME OF FATHER Henry Allen  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.  
12 MAIDEN NAME OF MOTHER Jessie Cole  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Laura Hollingeruth  
(Address) Shirley Mo.

15 Filed 3/26 1915  
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 / 26 1915  
(Month) (Day) (Year)

17 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..... m.

The CAUSE OF DEATH\* was as follows:  
159  
151  
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) (Duration)..... yrs..... mos..... ds.  
(Signed) no Phy. 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.

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 White Oak Grove DATE OF BURIAL 3/27 1915

20 UNDERTAKER J. B. Bryant Son ADDRESS Potosi Mo.

# 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, 8 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 organ; "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

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

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

County Washington Registration District No. 1080 File No. \_\_\_\_\_  
Township Walton or Village \_\_\_\_\_ Primary Registration District No. 6180 Registered No. 35  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME

Jessie Allen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH \_\_\_\_\_, 1915  
(Month) 3 (Day) 24 (Year)

DATE OF BIRTH \_\_\_\_\_, 1915  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 1915,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 1915,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ mins.

The CAUSE OF DEATH\* was as follows:  
don't know

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) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) No Physician there M. D.  
\_\_\_\_\_ 1915 (Address) \_\_\_\_\_

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) \_\_\_\_\_

\*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.

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

Where was disease contracted? \_\_\_\_\_  
If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

Filed March 24 1915 J. H. Henry REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1915  
UNDERTAKER: \_\_\_\_\_ ADDRESS \_\_\_\_\_

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DIAGONAL WATERMARK: SUPPLEMENTARY INFORMATION SUPPLIED

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Association]

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