

Persons dying away from home should be given in every instance. AGE should be carefully supplied. DEATH in plain terms, that it may be properly classified. The cause of death should be carefully supplied. AGE should be carefully supplied.

Place of Death

1. County of Clarke

2. Township of Ma.

3. City or Town of Alexandria St. 4712 Ward

4. FULL NAME Margaret Jane Adams

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

CERTIFICATE OF DEATH

189
4712

5. SEX Female 6. COLOR White

17. DATE OF DEATH
2 May 6
(Month) (Day) (Year)

7. DATE OF BIRTH
Feb 14 1857
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
Oct 1914 to May 1915
that I last saw her alive on May 6 1915
and that death occurred on the date stated above, at 5 P.M.

8. AGE
63 2 22
Year Month Day

18. P. M. The CAUSE OF DEATH was as follows:
Carcinoma of Liver and
Pyloic end of stomach
46B
46B (Duration) 40 Days

9. SINGLE, MARRIED
WIDOWED OR DIVORCED Married

10. BIRTHPLACE
(State or Country) Iowa

11. NAME OF FATHER Danford

12. BIRTHPLACE
OF FATHER (State or Country) Ohio

13. MAIDEN NAME
OF MOTHER Sartwell

14. BIRTHPLACE
OF MOTHER (State or Country) Indiana

15. OCCUPATION
Housewife

Contributory ✓ (Duration) 40 Days
19. (Signed) M. J. Gault M. D.
9 20. (Address) Keokuk, Ia.

21. SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents.
Former or Usual Residence Keokuk, Ia. How long at Place of Death? 40 Days
Where was disease contracted, if not at place of death? Keokuk, Ia.

The Above Stated Personal Particulars Are True to the Best of My Knowledge and Belief

16. (Informant) Amasa Deming
(Address) Alexandria, Mo.

22. PLACE OF BURIAL OR REMOVAL Yellow Bank Cemetery 23. DATE OF BURIAL May 9, 1915
24. UNDERTAKER J. S. Achley 25. ADDRESS Keokuk, Ia.

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UN FADING INK—THIS should be stated EXACTLY. PHYSICIANS should

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH
County *Clarke*
Township *Alexandria*
Village
City

Registration District No. *189* File No.

Primary Registration District No. *4112* Registered No.

(NO. _____) (St. _____ Ward)

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

2 FULL NAME *Margaret Jane Adams*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *May 6 1915*
(Month) (Day) (Year)

6 DATE OF BIRTH *Feb 14 1852*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Oct 1914* to *May 1915*
that I last saw her alive on *May 6 1915*

7 AGE *63* yrs. *2* mos. *22* ds. If LESS than 1 day.....hrs. or.....min.?

and that death occurred, on the date stated above, at *5* p. m.

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

The CAUSE OF DEATH* was as follows *Carcinoma of Liver & Pyloric End of Stomach*

9 BIRTHPLACE (City or town, State or foreign country) *York Pa.*

(Duration) yrs. mos. ds. *40*

10 NAME OF FATHER *Wm. Crawford*

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ohio*

(Signed) *J. D. Garout* (Address) *Morrow Ill*

12 MAIDEN NAME OF MOTHER *Wm. Sartwell*

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

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ind.*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Amund Deming*
(Address) *Alexandria Mo.*

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.....

15 Filed *May 7 1915*
F. A. S. Revo Registrar

19 PLACE OF BURIAL OR REMOVAL *Yellow Bank Cem.* DATE OF BURIAL *5-9 1915*
20 UNDERTAKER *J. S. Akley* ADDRESS *Keokuk Iowa*

Original file, date....., 19.....

All information called for must be written on this Supplementary Certificate.

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; Broncho-pneumonia* ("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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.; 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.)

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