

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

PLACE OF DEATH
Callaway

Ship ~~Jackson~~

Aux Vasse,

(NO. _____ St. _____ Ward)

Registration District No. 102 File No. 21194

Primary Registration District No. 4062 Registered No. 80

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

FULL NAME Susan H. Thomas.

PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH August 27, 1861
(Month) (Day) (Year)

IF LESS than 1 day, ___ hrs. or ___ min.?
53 yrs. 10 mos. 12 ds.

OCCUPATION
Profession, or kind of work Seamstress

Nature of Industry, or establishment in which employed (or employer) Dressmaking

PLACE OF BIRTH
Town, State or foreign country Callaway Co Mo.

NAME OF FATHER George Nathan Thomas.

PLACE OF BIRTH OF FATHER
Town, State or foreign country Callaway Co Mo.

NAME OF MOTHER Mary Ann Brown.

PLACE OF BIRTH OF MOTHER
Town, State or foreign country Warren Co Mo.

IF TRUE TO THE BEST OF MY KNOWLEDGE
Mary Ann Thomas

ADDRESS Auxvassé Mo.

DATE July 12, 1915
J. G. Thur
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 9th, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 7th, 1915, to July 9th, 1915, that I last saw her alive on July 9th, 1915, and that death occurred, on the date stated above, at 11 A.M. The CAUSE OF DEATH* was as follows:

Acute Uremia

Contributory (SECONDARY)
1.32
1.92 B (Duration) yrs. mos. 6 ds.

(Signed) J. H. Emerson M. D.
July 10, 1915 (Address) Auxvassé 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. - State ___ mos. ___ ds.

Where was disease contracted if not at place of death? July

Former or usual residence

PLACE OF BURIAL OR REMOVAL Grand Prairie DATE OF BURIAL July
UNDERTAKER Blanché ADDRESS Auxvassé Mo.

PLACE OF DEATH

MISSOURI STATE BOARD
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____) St. _____ Ward _____
(If death in hospital or of street car give No. and street address)

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH _____ (Month) _____, 191____, to _____ (Day) _____, 1____ (Year)

AGE _____ yrs. _____ mos. _____ ds. _____
IF LESS than
1 day _____ hrs. _____
or _____ min. ?

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)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended decease

_____ 191____, to _____

that I last saw him _____ alive on _____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed) _____

(Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRADING RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH: Laway, Platte County, Mo. Registration District No. 107, File No. 4062, Registered No. 80. PL NAME: Susan H. Thomas. (III death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS. 4 COLOR OR RACE: W. 5 SINGLE MARRIED WIDOWED OR DIVORCED. SEX: Female. BIRTH DATE: 1 (Year). AGE: yrs. mo. ds. OCCUPATION: (a) Trade, establishment in particular. (b) General business. BIRTHPLACE OF FATHER: (City or town, State or foreign country). BIRTHPLACE OF MOTHER: (City or town, State or foreign country). BIRTHPLACE OF DECEASED: (City or town, State or foreign country). IS TRUE TO THE BEST OF MY KNOWLEDGE. THE ABOVE (Informant). (A) 1914. Registrar.

MEDICAL CERTIFICATE OF DEATH. 16 DATE OF DEATH: July 9, 1915. 17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) (Year) to (Month) (Day) (Year), 1915. that I last saw him alive on (Month) (Day) (Year), 1915. and that death occurred, on the date stated above, at (Month) (Day) (Year), 1915. The CAUSE OF DEATH* was, as follows: Acute Pneumonia, Acute nephritis. (Duration) yrs. mos. ds. 6. CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. H. Emmons, M. D. 7-10-15 (Address) Aux Vasse Mo. *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. mo. ds. In the State yrs. mo. ds. Where was disease contracted if not at place of death? Former or usual residence. 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL. 20 UNDERTAKER ADDRESS.

Filed JUL -- 1915

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*, *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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);

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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.)